

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02495

2506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 70 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 543 GUILFORD AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VERNON Middle ROSWELL Last ADAMS		4. DATE OF DEATH Month FEBRUARY Day 19 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 17 Min.	11. IF UNDER 24 HRS. Months 7 Days 17 Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED METER SUPT.		10b. KIND OF BUSINESS OR INDUSTRY ELEC LIGHT PLANT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ADAMS		14. MOTHER'S MAIDEN NAME GENEVRA McCUNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. MARY V. ADAMS		18. HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertensive cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 15 mos. 18 mos. 7 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December , 19 58 , to Feb. 19 , 19 60 that I last saw the deceased alive on Feb. 18 , 19 60 , and that death occurred at 1:35 A M, from the causes and on the date stated above. EST ADDRESS (Street, city or town, state) DATE SIGNED 100 Professional Arts Bldg. 2/20/60			
ACTUAL SIGNATURE W. T. Layman		M.D. 100 Professional Arts Bldg. 2/20/60	
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/21/60	
22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
24b. REGISTRAR'S SIGNATURE William S. Fosse			

Journal of Management Education 26(7)

CERTIFICATE OF DEATH

Reg. Dist. No.

02496

2507

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VALERIE Middle ELIZABETH Last AMSLEY		4. DATE OF DEATH Month Feb. Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1959
9. AGE (In years lost birthday) yrs. 4		10. IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min. 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Ray Amsley		14. MOTHER'S MAIDEN NAME Carole Ann Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Carole Ann Smith		Address Hagerstown, Md. R#5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus with Spina 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bifida & Meningocele Extensive DUE TO (c) Malnutrition INTERVAL BETWEEN ONSET AND DEATH 4 mo 4 mo 22 days 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 17 , 19 59 , to 2/9/ , 19 60 , that I last saw the deceased alive on 2/8/ , 19 60 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 101 King St. Hagerstown, Md. DATE SIGNED 2/11/60			
ACTUAL SIGNATURE A. M. Bacon Jr M.D.			
PHYSICIAN'S NAME (Type) A. M. Bacon M.D. 101 King St. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/11/60	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2201

1

2

3

Decedent's Name: *John Doe*
Age: *45*
Sex: *Male*
Race: *White*
Date of Birth: *Jan 1, 1925*
Place of Birth: *New York City*
Usual Residence: *123 Main St, New York City*
Cause of Death: *Heart Disease*
Date of Death: *Dec 15, 1970*
Place of Death: *Home*
Physician: *Dr. J. Smith*
Manner of Death: *Natural*
Signature of Physician: *[Signature]*
Signature of Medical Examiner: *[Signature]*
Signature of Coroner: *[Signature]*

[Faint, illegible text, possibly bleed-through from the reverse side]

State of New York
County of New York
City of New York
Office of the Coroner
New York City

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 2508
 CERTIFICATE OF DEATH

02497

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 Alexander St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Constan Middle Athan Last Athan				4. DATE OF DEATH Month 2 Day 18 Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1881		9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) antique dealer		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nettie Athan		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with decompensation DUE TO (c) General arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis of legs (b) Acute upper respiratory infection							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Feb 5, 1960 to Feb 12, 1960 , that (I) (we) last saw the deceased alive on Feb 12, 1960 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III, M.D.				22b. DATE SIGNED 2/18/60		22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.	
22d. ADDRESS 217 West Washington Street		23a. BURIAL, CREMATION, REMOVAL (Specify) burial					
23b. DATE THEREOF 2-20-60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.		24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss	
25a. REC'D BY REGISTRAR FEB 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

RECEIVED

2020

CHIEF OF POLICE

W. J. M. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2605

CERTIFICATE OF DEATH

Reg. Dist. No.

02498

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leitersburg</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leitersburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>Bowman</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 2, 1880</u>	
9. AGE (In years last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>24</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		
11. BIRTHPLACE (State or foreign country) <u>Wash. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>(First name not known) Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Martha Brunner</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		
INFORMANT <u>Mrs. Cleona Locker Leitersburg, Md.</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized atherosclerosis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>		
21. I certify that I attended the deceased from <u>Feb 16, 1960</u> to <u>Feb 26, 1960</u> that I last saw the deceased alive on <u>Feb 19, 1960</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>Mrs. S. J. [illegible]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>28 W Potomac 2-2760</u>		
PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		<u>Williamsport Md</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Bakersville Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>		
ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 29 60</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur A. [illegible]</u>				

— 1997 —

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02499

Reg. Dist. No. 302

2500

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 1 440 Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVA Middle KAY Last BARNHART		4. DATE OF DEATH Month February Day 7 Year 19 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 17, 1960		9. AGE (In years last birthday) yrs. 21 Months 21 Days 21 Hours 21 Min. 21		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald L. Barnhart				14. MOTHER'S MAIDEN NAME Joyce M. Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Donald L. Barnhart Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.0 DUE TO Hemorrhagic Congestion of Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Wet Pneumonia (c) Aspiration of Vomitus </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH 12 hr intermittent </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE J. E. Suter M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) J. E. Suter			DATE SIGNED 2/9/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Garden			
22d. LOCATION (City, town, or county) (State) Hagerstown Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home 2 Franklin Avenue				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE FEB 15 '60 Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

208126 3XU5

MEDICAL EXAMINER'S CERTIFICATE OF DEATH MAYNARD STATE DEPARTMENT OF HEALTH - BARNHART 10

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "New York"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1920"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF EXAMINER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "Albany"]		STATE [Faint text, possibly "New York"]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE DEPARTMENT OF SOCIAL SERVICES.

CERTIFICATE OF DEATH

Reg. Dist. No. 302

2510

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

4 Days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

03 Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Wash County Hospital

d. STREET ADDRESS

603 Wise St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

LULU

Middle

BELLE

Last

BARR

4. DATE OF DEATH

Month

Feby 17 1960

Day

Year

19

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

Jany 27 1879

9. AGE (In years last birthday)

81 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Box Maker

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Barr

14. MOTHER'S MAIDEN NAME

Katie Oster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

314-09-7206

INFORMANT

Address

Mrs Pearl Hull 312 Bryan Place

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO

(c)

Hagerstown Md.

INTERVAL BETWEEN ONSET AND DEATH

4 days

year

year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 14 Feb., 1960, to 17 Feb., 1960, that I last saw the deceased alive on 17 Feb., 1960, and that death occurred at 9:20 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

Eldon D Hoachlander M.D.

115 W. Wash St 2/18/60

PHYSICIAN'S NAME (Type)

Eldon D Hoachlander Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2/20/60

22c. NAME OF CEMETERY OR CREMATORY

Rose Hill Cemetery

22d. LOCATION (City, town, or county)

Hagerstown Wash Co Md

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR

DATE

FEB 23 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kins

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1903

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1902

ALBANY:

WATKINS & COMPANY, PRINTERS

1903

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS Route #1. (Wolfsville)	
3. NAME OF DECEASED (Type or print) First Middle Last HATTIE MAE BEAR		4. DATE OF DEATH February 1 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1895
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Simon P. Eccard	
14. MOTHER'S MAIDEN NAME Effie Shuff		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT John M. Bear, Smithsburg, Md. Rt #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Diabetes Melitus			INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. 8 yrs. 22 Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large Ovarian Cyst			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-2, 1960, to 2-1, 1960, that I last saw the deceased alive on 2-1, 1960, and that death occurred at 4:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		DATE SIGNED 2-1-60	
PHYSICIAN'S NAME (Type) Dr. Charles F. Hess		Smithsburg, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Feb. 4, 1960	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY United Brethern	22d. LOCATION (City, town, or county) (State) Wolfsville, Fred. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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DECEASED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02502

2512

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 48 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EFFIE Middle TERESA Last BECKLEY				4. DATE OF DEATH Month Feb. Day 10 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1894	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator				10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Carroll Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Graham				14. MOTHER'S MAIDEN NAME Anna Dayhoff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-16-2095			
17. INFORMANT Mr. Chas. R. Beckley				Address 911 Kenly Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis & infarction DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO years. (c) Arteriosclerotic hypertensive CIVT. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aneurysm, abd. aorta. INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2 Mar , 19 57 , to 10 Feb , 19 60 , that I last saw the deceased alive on 9 Feb , 19 60 , and that death occurred at 7:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1135 POTOMAC AVENUE DATE SIGNED 12 FEB. 1960							
ACTUAL SIGNATURE Richard T. Binford							
PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.				HAGERSTOWN, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Monk				ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2513

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

02503

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>unknown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>36 N. Walnut St.</u>				d. STREET ADDRESS <u>36 N. Walnut Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>BLACK</u> Last <u>BLACK</u>				4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1887</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Painter</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>220-26-5705</u>		17. INFORMANT <u>Washington Co. Welfare Dept. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> DUE TO <u>arterio-sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u> </u> (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>J. E. W. Smith</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>J. E. W. Smith</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/12/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Berger</u>				ADDRESS <u>Hagerstown Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. Hous</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

02504

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg rural		c. LENGTH OF STAY IN 1b 39 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg rural							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. #2						d. STREET ADDRESS R. D. #2			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Delia			Middle Sipple			Last Bollinger			4. DATE OF DEATH Month Feb.			Day 10		Year 19 60			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1886		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73		IF UNDER 24 HRS. Days 73		Hours 73		Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME George Friese						14. MOTHER'S MAIDEN NAME Nettie Sipple											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none				INFORMANT Mr. William Bollinger				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Coronary artery sclerosis DUE TO (c) Generalized Arterio sclerosis												INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 104 hrs. 15 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 6-11 , 19 52 to 2-10 , 19 60 , that I last saw the deceased alive on 2-9 , 19 60 , and that death occurred at 5A.M. , from the causes and on the date stated above.																	
ACTUAL SIGNATURE Walter H. Wishard										M.D. Waynesboro, Penna.		DATE SIGNED 2-10-60					
PHYSICIAN'S NAME (Type) Walter H. Wishard										Waynesboro, Penna.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-12-60		22c. NAME OF CEMETERY OR CREMATORY Leithersburg Lutheran Cem.				22d. LOCATION (City, town, or county) Leithersburg Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.						ADDRESS Smithsburg, Md.		24a. REC'D BY REGISTRAR FEB 15 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____
12. Place of registration: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

02505

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b <u>life time</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				/ d. STREET ADDRESS <u>464 Park Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Allan Burnett Jr.</u>		4. DATE OF DEATH Month Day Year <u>Feb 27 1960</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 19 1921</u>		9. AGE (In years lost birthday) <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>William A Burnett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Georgia Burnett 464 Park Place</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Glomerular nephritis</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 23</u> , 19 <u>60</u> , to <u>Feb 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 27</u> , 19 <u>60</u> , and that death occurred at <u>8</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		M.D. <u>1590. Washington & Hagerstown Rd.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>2/28/60</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson of Hagerstown, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine E. Kiser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

REG. DIST. NO.

1. NAME OF DECEASED [Handwritten: John Doe]		2. SEX [Handwritten: Male]		3. AGE [Handwritten: 45]		4. RACE [Handwritten: White]		5. DATE OF BIRTH [Handwritten: 10/15/1910]		6. PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
7. DATE OF DEATH [Handwritten: 11/10/1955]		8. TIME OF DEATH [Handwritten: 10:30 AM]		9. PLACE OF DEATH [Handwritten: Home]		10. CAUSE OF DEATH [Handwritten: Myocardial Infarction]		11. MANNER OF DEATH [Handwritten: Natural]		12. SIGNATURE OF PHYSICIAN [Handwritten: Dr. J. Smith]	
13. SIGNATURE OF REGISTRAR [Handwritten: J. Doe]		14. SIGNATURE OF WITNESS [Handwritten: J. Doe]		15. SIGNATURE OF WITNESS [Handwritten: J. Doe]		16. SIGNATURE OF WITNESS [Handwritten: J. Doe]		17. SIGNATURE OF WITNESS [Handwritten: J. Doe]		18. SIGNATURE OF WITNESS [Handwritten: J. Doe]	
19. SIGNATURE OF WITNESS [Handwritten: J. Doe]		20. SIGNATURE OF WITNESS [Handwritten: J. Doe]		21. SIGNATURE OF WITNESS [Handwritten: J. Doe]		22. SIGNATURE OF WITNESS [Handwritten: J. Doe]		23. SIGNATURE OF WITNESS [Handwritten: J. Doe]		24. SIGNATURE OF WITNESS [Handwritten: J. Doe]	
25. SIGNATURE OF WITNESS [Handwritten: J. Doe]		26. SIGNATURE OF WITNESS [Handwritten: J. Doe]		27. SIGNATURE OF WITNESS [Handwritten: J. Doe]		28. SIGNATURE OF WITNESS [Handwritten: J. Doe]		29. SIGNATURE OF WITNESS [Handwritten: J. Doe]		30. SIGNATURE OF WITNESS [Handwritten: J. Doe]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

CERTIFICATE OF DEATH

02506

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BIG POOL		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESIDENCE BIG POOL, MD.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILBUR Middle HARVEY Last CAMERON		4. DATE OF DEATH Month FEB. Day 15 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 21, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY VICTOR PRODUCTS	
11. BIRTHPLACE (State or foreign country) FRONT ROYAL, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES H. CAMERON		14. MOTHER'S MAIDEN NAME OCTAVA M. MOLDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-5912	
17. INFORMANT J.W. CAMERON		Address RD. 1. CLSPG. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: VIRAL PNEUMONIA IMMEDIATE CAUSE (a) 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from FEBRUARY 10, 1960 , to FEBRUARY 15, 1960 , that I last saw the deceased alive on FEBRUARY 14, 1960 , and that death occurred at 5.00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.			
PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		CLEAR SPRING, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 18, 1960	
22c. NAME OF CEMETERY OR CREMATORY SHANKTOWN CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i>		ADDRESS CLEAR SPRING, MD.	
24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2608

CERTIFICATE OF DEATH

Reg. Dist. No.

02507

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro R#2		c. LENGTH OF STAY IN 1b 2 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boonsboro R#2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLEN Middle MALLVERNA Last CASTLE		4. DATE OF DEATH Month Feb. Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1878
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 81 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor - knitting		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (State or foreign country) Near Rohrsersville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis O. Castle		14. MOTHER'S MAIDEN NAME (Wash. Co.) Ellen D. Castle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-09-1546	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) 2 months		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 12-12-1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-12-1959 to 2-1-1960 , that I last saw the deceased alive on 2-1-1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro Md. DATE SIGNED Joseph S. Secordari			
ACTUAL SIGNATURE Joseph S. Secordari M.D.		PHYSICIAN'S NAME (Type) JOSEPH SECONDARI BOONSBORO MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/6/60	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

2000

Washington

Boonville R.R.

Boonville R.R.

ELITE

WILLIAM

DAVID

John H. Smith

John H. Smith

10-20-1900

10-20-1900

10-20-1900

10-20-1900

10-20-1900

10-20-1900

10-20-1900

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02508

2515
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>10 Days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>1 24 Delwood Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>McKEE</u> Last <u>CLIPP</u>		4. DATE OF DEATH Month <u>Feby</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>	11. IF UNDER 24 HRS. Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Chewsville Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Emory McKee</u>		14. MOTHER'S MAIDEN NAME <u>Ida Clopper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
INFORMANT Address <u>Chester J. Clipp 24 Delwood Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u> <u>153.8</u> DUE TO (b) <u>with metastasis & hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 23, 1956</u> to <u>Feb 8, 1960</u> that I last saw the deceased alive on <u>Feb 8, 1960</u> , and that death occurred at <u>2:00 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. L. Packer, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>145 W. Washington St.</u> DATE SIGNED <u>2/9/60</u>	
PHYSICIAN'S NAME (Type) <u>L. L. Packer, Jr., M.D.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 11 '60</u> 24b. REGISTRAR'S SIGNATURE <u>C. J. H. H. H.</u>	

CERTIFICATE OF DEATH

2018

11

155 W. Washington St.

Hammond, Ind.

Dr. J. J. ...

2609
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Md				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				d. STREET ADDRESS W. Main St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jennie Middle Taylor Last Conn				4. DATE OF DEATH Month 2 Day 16 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12.25.1869		9. AGE (In years last birthday) yrs. 90	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Clothing Store		11. BIRTHPLACE (State or foreign country) Washington Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hixon				14. MOTHER'S MAIDEN NAME Eliza Creager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Beteran Conn Hancock Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 hour 10-15 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 28 , 19 59 , to 2-16 , 19 60 , that I last saw the deceased alive on Jan. 5 , 19 60 , and that death occurred at 12:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hancock, Md DATE SIGNED 2-18-60 ACTUAL SIGNATURE Frank B. Thomas III M.D. PHYSICIAN'S NAME (Type) Frank B. Thomas III MD Hancock, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2.18.60		22c. NAME OF CEMETERY OR CREMATORY Episcopal Cemetery		22d. LOCATION (City, town, or county) (State) Hancock Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Shreve Hancock Md				24a. REC'D BY REGISTRAR DATE FEB 23 '60		24b. REGISTRAR'S SIGNATURE William S. HARR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. J. AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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060125

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G256 2-23-60 et

CERTIFICATE OF DEATH

02510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1028 Pennsylvania Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MCKINLEY Last COSEY		4. DATE OF DEATH Month Feb. Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 5 Days 25 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (State or foreign country) Franklin County, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Correct name unknown		14. MOTHER'S MAIDEN NAME Nora Cosey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-2240	
INFORMANT Mrs. Wm. Cosey		Address 1028 Penna. Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Hypertensive cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 5 mins. 9 years 18 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 15, 1960 , to February 15, 1960 , and that death occurred at 11:30 AM , from the causes and on the date stated above. EST ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. 2/16/60 DATE SIGNED			
ACTUAL SIGNATURE <i>William T. Layman</i>		M.D. 100 Professional Arts Bldg. 2/16/60	
PHYSICIAN'S NAME (Type) William T. Layman		Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18/60	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR FEB 18 1960	
24b. REGISTRAR'S SIGNATURE <i>Wm. C. Hart</i>			

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Reg. Dist. No.

02511

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md				c. LENGTH OF STAY IN 1b 25 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle Mae Last Cottrill				4. DATE OF DEATH Month February Day 1 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.27.1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 5 Days 3 Hours 1 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switch Board Operator C&P. Telephone				10b. KIND OF BUSINESS OR INDUSTRY Washington County Md			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William A Barger				14. MOTHER'S MAIDEN NAME Hennietta Rider			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-22-7594			
17. INFORMANT Mrs Phyllis Rogers Williamsport Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Codwary Larson Ross 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/1/60 , 19 to 2/1/60 , 19, that I last saw the deceased alive on 2/1/60 , 19, and that death occurred at 3 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ralph L. Young M.D. Williamsport Md 2/3/60							
ACTUAL SIGNATURE Ralph L. Young							
PHYSICIAN'S NAME (Type) Ralph L. Young							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2.4.1960			
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery				22d. LOCATION (City, town, or county) (State) Williamsport Washington Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone Hancock Md				24a. REC'D BY REGISTRAR DATE FEB 8 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Fraw							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAVY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2517

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 40 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Maryland			
				d. STREET ADDRESS 52 W. Bethel Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha First Viola Middle Craig Last				4. DATE OF DEATH Feb Month 12 Day 19 Year 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 25 1889	
				9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Clear Spring, Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Samuel Craig				14. MOTHER'S MAIDEN NAME Sarah Dartz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-24-9731		17. INFORMANT Address Mrs. Carrie Bell 311 W. Potomac St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Cancer 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sev. wks. sev. mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/27/54 , 19____, to 2/12/60 , 19____, that I last saw the deceased alive on 2/12/60 , 19____, and that death occurred at 11:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac Street DATE SIGNED 2/15/60 ACTUAL SIGNATURE Howard N. Weeks, M.D. Hagerstown, Maryland PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 16 1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.				24a. REC'D BY REGISTRAR DATE FEB 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of the formation of the state is the creation of a common identity among the people. This is achieved through the establishment of a common language, culture, and religion. The second step is the creation of a common political system, which is achieved through the establishment of a common law and a common government. The third step is the creation of a common economic system, which is achieved through the establishment of a common market and a common currency. The fourth step is the creation of a common social system, which is achieved through the establishment of a common education system and a common health system. The fifth step is the creation of a common defense system, which is achieved through the establishment of a common army and a common navy. The sixth step is the creation of a common foreign policy, which is achieved through the establishment of a common diplomatic corps and a common foreign minister. The seventh step is the creation of a common justice system, which is achieved through the establishment of a common court system and a common judge. The eighth step is the creation of a common culture, which is achieved through the establishment of a common language, a common religion, and a common art. The ninth step is the creation of a common economy, which is achieved through the establishment of a common market, a common currency, and a common trade system. The tenth step is the creation of a common society, which is achieved through the establishment of a common education system, a common health system, and a common social system. The eleventh step is the creation of a common state, which is achieved through the establishment of a common political system, a common economic system, a common social system, a common defense system, a common foreign policy, a common justice system, a common culture, a common economy, and a common society. The twelfth step is the creation of a common world, which is achieved through the establishment of a common international system, a common global economy, a common global society, a common global defense system, a common global foreign policy, a common global justice system, a common global culture, a common global economy, and a common global society.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

02513

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 29 N. Locust Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUSSELL First FLOYD Middle CROMER Last		4. DATE OF DEATH February Month 27 Day 19 Year 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1994
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Cromer		14. MOTHER'S MAIDEN NAME Rosanna Winkfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W. I		16. SOCIAL SECURITY NO. 219-05-2122	
17. INFORMANT Mrs. Genevieve Anspacher Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Heart Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. W. Suter M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. D. T. To Jr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/1960	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home Hagerstown, Md.		24a. REC'D BY REGISTRAR MAR 2 '60 DATE	
		24b. REGISTRAR'S SIGNATURE William S. Tinsley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 02514

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carlack Comm. Home</u>				d. STREET ADDRESS <u>E. Madison St</u>			
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>K. Crunkilton</u> Last <u></u>				4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 9, 1870</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Emma Ridenour</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT <u>Mr. Joseph H. Crunkilton, Delington, Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> (c) <u>3 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-12-60</u> 19 <u>60</u> , to <u>2-23</u> 19 <u>60</u> , that I last saw the deceased alive on <u>2-23-60</u> 19 <u>60</u> , and that death occurred at <u>noon</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>2/24/60</u>			
PHYSICIAN'S NAME (Type) <u>D. E. W. [Signature]</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>2/28/1960</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co. Penna</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman, Greencastle Pa</u>			
24a. REC'D BY REGISTRAR <u>FEB 29 '60</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2520
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> Co. <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>EDWARD</u> Last <u>DALEY</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12 1907</u>	9. AGE (In years lost birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pa. Mercersburg Franklin Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman T. Daley</u>				14. MOTHER'S MAIDEN NAME <u>Gladys Gorman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>Mrs Mary A. Glenn 728 George St</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>480X</u> IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Le. fulpe</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-7</u> , 19 <u>60</u> , to <u>2-14</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>2-13-60</u> , 19 <u> </u> , and that death occurred at <u>3:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. E. Dittus</u>		M.D. <u>Hagerstown Md</u>		DATE SIGNED <u>7/15/60</u>			
PHYSICIAN'S NAME (Type) <u>DR F W DITTO</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Date of registration: _____

2521

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle NORMA Last DAUGHERTY		4. DATE OF DEATH Month February Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Shepherdstown, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Fisher		14. MOTHER'S MAIDEN NAME Margaret Fayman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Clyde A. Daugherty		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerosis generalized 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart left by aneurysm 1 week prior to death. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/5/60 , 19___, to 2/26/60 , 19___, that I last saw the deceased alive on 2/26/60 , 19___, and that death occurred at 6P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac St. DATE SIGNED 2/27/60 ACTUAL SIGNATURE Howard N. Weeks, M.D. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/1960	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home Hagerstown, Maryland		24a. REC'D BY REGISTRAR MAR 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2551

Decedent's Name: [Illegible]
Sex: [Illegible] Age: [Illegible]
Date of Birth: [Illegible]
Place of Birth: [Illegible]
Usual Residence: [Illegible]
Cause of Death: [Illegible]
Date of Death: [Illegible]
Place of Death: [Illegible]
Physician: [Illegible]
Hospital: [Illegible]
Burial Place: [Illegible]
Signature: [Illegible]

[Illegible text, likely a continuation of the certificate or a separate document, heavily obscured by stains and bleed-through.]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02517

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 19 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		/d. STREET ADDRESS 351 N. Cannon Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mabel Edith Downs		4. DATE OF DEATH Month February Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1894
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Near Mt. Crawford Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Turner J. Burgess		14. MOTHER'S MAIDEN NAME Nellie Wilhite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
INFORMANT Mrs. Carol Smith Hag. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis. 332x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Essential Hypertension.			
INTERVAL BETWEEN ONSET AND DEATH 6 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19, 1960 to Feb. 24, 1960 that I last saw the deceased alive on February 24, 1960 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. A. Bell		ADDRESS (Street, city or town, state) 119 N. Potomac St.	
DATE Feb. 24, 1960		DATE SIGNED	
PHYSICIAN'S NAME (Type) R. A. Bell		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-60	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

1922

Washington

Washington

Washington

Hagerstown

19 years

Hagerstown

351 N. Cannon Ave.

Washington County Hospital

20

February 24

Death

Edith

Name

Jan. 10, 1894

White

Female

West Mt. Crawford Va.

Own Home

House 211

White

Turner J. Burgess

Mar. 10

April

May

June

July

Aug.

Sept.

October

November

December

119 N. Potomac St.

Hagerstown Md.

Hagerstown Md.

Hagerstown Md.

Hagerstown Md.

Hagerstown Md.

Hagerstown Md.

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG256 2-11-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02518

2523

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hoptl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print!) First <u>Maude</u> Middle <u>C</u> Last <u>Earl</u>		4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-75</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Alfred B. Conway</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Senore Miller</u> Address <u>612 Monroe St. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac rupture, left ventricle</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myo cardial infarction</u> DUE TO (c) <u>Acute coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 days</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 11</u> , 19 <u>57</u> to <u>Feb. 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 7</u> , 19 <u>60</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1500 Penna Ave. Hagerstown, Md.</u> DATE SIGNED <u>Feb 7 1960</u>			
ACTUAL SIGNATURE <u>Young E. Chun</u>		M.D. <u>1500 Penna Ave. Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Young E. CHUN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-8-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>7. H. 1331 Montz. Ave. Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1001 M-4-31110

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1001

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 Week</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>846 Frederick St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>LEWIS</u> Last <u>EARLEY</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 18 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Earley</u>		14. MOTHER'S MAIDEN NAME <u>Laura Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-6967</u>	
17. INFORMANT <u>Mrs Myra Kefauver</u>		Address <u>846 Frederick St Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage into the stomach</u> DUE TO (c) <u>Gastric Ulcer with hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u> <u>hrs.</u> <u>hrs. days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis Generalized advanced</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u> </u> , to <u>Feb 1, 1960</u> , that I last saw the deceased alive on <u>January 30, 1960</u> , and that death occurred at <u>3:30 AM</u> the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 E. Antietam St.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Louis G. Graff</u>		M.D. <u>119 E. Antietam St.</u>	
PHYSICIAN'S NAME (Type) <u>Louis G. Graff, MD.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/3/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

5834

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2525

CERTIFICATE OF DEATH

Reg. Dist. No.

02520
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>15 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>ROSCOE</u> Last <u>FLEMING</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 26 1893</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward E. Fleming</u>				14. MOTHER'S MAIDEN NAME <u>Cora A. Harnish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-8680</u>		INFORMANT <u>Mrs Emma C. Shaffer 413 Clarendon</u> Address <u>NAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pulmonary congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart dis.</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 57</u> to <u>14 Feb 60</u> , that I last saw the deceased alive on <u>14 Feb 1960</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard T. Binford</u>				ADDRESS (Street, city or town, state) <u>MD. 1135 POTOMAC AVENUE</u>		DATE SIGNED <u>16 FEB. 1960</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M. D.</u>				<u>HAGERSTOWN, MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 17 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harnish</u>	

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1925

100-100000

100-100000

100-100000

100-100000

100-100000

2526

CERTIFICATE OF DEATH

Reg. Dist. No. 302

02521

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>7 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JETTIE</u> Middle <u>MAE</u> Last <u>FORTUNATO</u>				4. DATE OF DEATH <u>Feby 11 1960</u> 19 <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1894</u>	9. AGE (In years last birthday) yrs. <u>65</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Shenandoah Page Co Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Henry</u>				14. MOTHER'S MAIDEN NAME <u>Mary Walters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>Samuel Fortunato Sr</u>		Address <u>Hagerstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adequatous Ynter</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-5</u> , 19 <u>60</u> , to <u>2-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-11</u> , 19 <u>60</u> , and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Salton M. Wally</u>		M.D. <u>Hagerstown, Md</u>		ADDRESS (Street, city or town, state) <u> </u>		DATE SIGNED <u>2-12-60</u>	
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2526

MAINTAINED

MAINTAINED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Page 4
DR. MRS. BYRKIT
28 W. POTOMAC ST
WILLIAMSPORT

2602

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02522

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLIAMSPORT</u>			c. LENGTH OF STAY IN 1b <u>ONE DAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH First Middle Last <u>ANNA MARY FRIEND</u> Month Day Year <u>FEBRUARY - 19 - 1960</u>			5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JULY - 3 - 1880</u>			9. AGE (In years lost birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. CO. MD. U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES DALLAS HOOVER</u>			14. MOTHER'S MAIDEN NAME <u>AMANDA S. BRILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>HARRY B. FRIEND</u> Address <u>FAIRPLAY MD. R.1</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic C.V.D.</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>481X Influenza</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		
20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> 19 <u>58</u> to <u>Feb 19</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Feb 18</u> 19 <u>60</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.						
22a. SIGNATURE <u>M.E. Byrkit</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2-20-60</u>						
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u> 22d. ADDRESS <u>28 W Potomac Wmpt Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 21 - 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		
23d. LOCATION (City, town, or county) <u>HAGERSTOWN MD.</u>		(State) <u></u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bass</u> ADDRESS <u>BOONSBORO MD.</u>						
25a. REC'D BY REGISTRAR <u>FEB 23 '60</u> 25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>						

00000

CERTIFICATE OF DEATH

3602

1

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02523

2610

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield		c. LENGTH OF STAY IN 1b 5 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margie Middle Elizabeth Last Gaver				4. DATE OF DEATH Month Feb. Day 17, Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1886		9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lantz Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cyrus Davis				14. MOTHER'S MAIDEN NAME Sarah Ambrose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 195-26-1743		17. INFORMANT J. Lloyd Gaver, Highfield Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1948 to Feb 16 , 19 60 , that I last saw the deceased alive on Feb 16 , 19 60 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert A. Thufur M.D. Bethel Ridge, Pa. Feb 14, 60							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Lantz #1 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Grove, Waynesboro Pa.				ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. O'NEILL		M		45		JAN 15 1900		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
100 N. BROAD ST. BOSTON		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 20 1945		10:30 AM		10		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. J. O'NEILL		J. J. O'NEILL		J. J. O'NEILL		J. J. O'NEILL		J. J. O'NEILL	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02524

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 919 Mulberry Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle Ann Last Gerrard				4. DATE OF DEATH Month February Day 7 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1879		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mapleville Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Valentine				14. MOTHER'S MAIDEN NAME Barbara Gaylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-09-3000B		17. INFORMANT Address Mrs. Asbury Hoover Wolfsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Entire upper chest crushing DUE TO (c) Compound Fracture Femur (left & rt) instant							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car descending hill left road crashed into tree					
20c. TIME OF INJURY Month, Day, Year Hour 5:30 p. m. 2-7-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public Road Smithsburg Wash Md		20f. (City or town) (County) (State) Smithsburg Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE [Signature]				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/9/60	
EXAMINER'S NAME (Type) DAE W. J. T. T. O. F.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-60		22c. NAME OF CEMETERY OR CREMATORY Fahrney Cemetery		22d. LOCATION (City, town, or county) (State) Near Mapleville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR DATE FEB 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased Robert E. Manning		Sex Male		Age 35		Date of Birth 1910-05-15	
Place of Birth Baltimore, Md.		Usual Residence Baltimore, Md.		Cause of Death Heart Disease		Manner of Death Natural	
Occupation None		Education High School		Previous Illnesses None		Time of Death 1945-05-15	
Signature of Physician J. Edgar Hoover		Signature of Medical Examiner J. Edgar Hoover		Signature of Coroner J. Edgar Hoover		Signature of Registrar J. Edgar Hoover	
City Baltimore		County Baltimore		State Maryland		Date of Report 1945-05-15	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02525

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 919 Mulberry Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Peter Gerrard		4. DATE OF DEATH Month Day Year February 7 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Voice piper		10b. KIND OF BUSINESS OR INDUSTRY Organ	
11. BIRTHPLACE (State or foreign country) Ontario Canada		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Gerrard		14. MOTHER'S MAIDEN NAME Marion Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-3000A	
17. INFORMANT Mr. Hugh A. Gerrard		Address Santa Anna Calif.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull DUE TO Entire upper chest crushed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of Femur DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car descending hill left road crushed into tree	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 2-7 1960 2:30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public Road Smithsburg Wash. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE J. E. W. Smith		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) J. E. W. Smith		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/9/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-60	
22c. NAME OF CEMETERY OR CREMATORY Fahney Cemetery		22d. LOCATION (City, town, or county) (State) Near Mapleville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR FEB 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02526

2527

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland Chronic Hospital				d. STREET ADDRESS 238 West Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Edward Gittinger				4. DATE OF DEATH Month Day Year Feb. 29 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 8, 1903		9. AGE (In years less birthday) yrs. 56	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Super-Market		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Gittinger				14. MOTHER'S MAIDEN NAME Katie Lee Ketler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-1364		INFORMANT 218 West Fifth Street, Mrs. Elizabeth Green, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary occlusion DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) old myocardial infarction. 2) Old coronary occlusion 3) Pulmonary embolism.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 24 , 1960, to Feb. 29 , 1960, that I last saw the deceased alive on February 29 , 1960, and that death occurred at 9:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Victor L. Ramos M.D. Western Maryland State Hospital Feb 29, 1960				PHYSICIAN'S NAME (Type) Victor L. Ramos Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE MAR 2 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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CERTIFICATE OF DEATH

STATE

County of

City of

Deceased

Age

Sex

Married

Date of Death

Place of Death

Cause of Death

Signature

Witness

Physician

Minister

Funeral Home

Interment

Place of Burial

Time of Burial

Signature of Deceased

Signature of Next of Kin

Signature of Minister

This certificate is valid only when countersigned by the proper authorities.

CERTIFICATE OF DEATH

Reg. Dist. No.

02527

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Hosp</u>				d. STREET ADDRESS <u>Route #2</u>			
3. NAME OF DECEASED (Type or print) First <u>Adam</u> Middle <u>Leslie</u> Last <u>Goetz</u>				4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 24 1975</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Thomas M. Goetz</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Roots</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mrs. Henry Cordell Greencastle, Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Arteriosclerotic heart Disease</u> DUE TO <u>with Decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>1090</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 Mar</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0 Prosthetic aortic valve, bicuspid</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb 16</u> , 1960, to <u>Feb 18</u> , 1960, that I last saw the deceased alive on <u>Feb 18</u> , 1960, and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.				ADDRESS (Street, city or town, state) <u>212 W. Washington St</u>			
DATE SIGNED <u>2/19/60</u>				PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, MD</u> <u>Hagerstown, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co. Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley M. Zimmerman</u>				ADDRESS <u>Greencastle Pa</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02528

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg d. STREET ADDRESS RFD 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA LILLIAN GOUKER		4. DATE OF DEATH FEB. 16 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1908
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic servant		10b. KIND OF BUSINESS OR INDUSTRY home work	
11. BIRTHPLACE (State or foreign country) Greensburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Gouker		14. MOTHER'S MAIDEN NAME Katherine Santz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-34-0570	
17. INFORMANT Paul Gouker, Waynesboro, Penna.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONFLUENT LOBULAR PNEUMONIA LOWER LOBES BILATERAL DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) CARCINOMA RIGHT BREAST WITH METASTASES DUE TO (c) 4 1/2 MONTHS INTERVAL BETWEEN ONSET AND DEATH 7 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 25, 1960 to FEB. 16, 1960 , that (I) (we) last saw the deceased alive on FEB. 16, 1960 , and that death occurred at 3:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE George Beren		22b. DATE SIGNED FEB. 17, 1960	
22c. PHYSICIAN'S NAME (Type) DR. GEORGE BERCU		22d. ADDRESS 1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-19-60	
23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		25a. REC'D BY REGISTRAR FEB 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

100-257

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR

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Marriage License

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

2530

02520

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS R.F.D. # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BETTY Middle LILLIAN Last GRAFFIUS				4. DATE OF DEATH Month February Day 1 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1880		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tilghmanton District, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Moats				14. MOTHER'S MAIDEN NAME R.becca Rohrer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Jane E. Clem Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (b) pulmonary embolism (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE A. E. W. J. T. F. O. J. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) A. E. W. J. T. F. O. J.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home A. Franklin Rye				24a. REC'D BY REGISTRAR FEB 4 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02530

2613

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock RFD #1</u>		c. LENGTH OF STAY IN 1b <u>48 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hancock RFD #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>Elverson</u> Last <u>Graham</u>				4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-6-1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Western Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Davis W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Graham</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-7946</u>		17. INFORMANT <u>Mary Elizabeth Graham Hancock RFD #1</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity and Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>at Death</u> <u>7:40</u> <u>PM</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>60</u> , and that death occurred at <u>11:30</u> <u>PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sam Nichols</u> M.D.				DATE SIGNED <u>2/10/60</u>			
PHYSICIAN'S NAME (Type) <u>Sam Nichols</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catalpa Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock RFD #1 Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kathleen M. Laine</u>				ADDRESS <u>Hancock Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 15 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2531

CERTIFICATE OF DEATH

Reg. Dist. No.

02531

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Green		4. DATE OF DEATH Month February Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1877
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick County Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Wauggman		14. MOTHER'S MAIDEN NAME Eva Utz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-1696	
17. INFORMANT Isiah H. Green		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Atherosclerosis - Gen -		INTERVAL BETWEEN ONSET AND DEATH 4 day Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 54 , to Feb 22 , 19 60 , that I last saw the deceased alive on Feb 22 , 19 60 , and that death occurred at 5:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 2/23/60			
ACTUAL SIGNATURE Louis S. Shell		M.D. Louis G. Grafton	
PHYSICIAN'S NAME (Type) Louis G. Grafton			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR FEB 25 '60	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

Robert W. Minnihan & Son, Hagerstown, Md.
1-15-50
1000 Hill Cemetery, Hagerstown, Md.

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page]

John Neumann
210-19-1000 John H. Green Hagerstown, Md.
Live Use

Housewife Own Home Frederick County, Md.

Female White Oct. 27, 1897 82

Married Green February 28

Hagerstown County Hospital 719 Spruce St.

Hagerstown 50 Years Hagerstown

Hagerstown

CERTIFICATE OF DEATH

223

2532

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) 838 MARYLAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN First MAE Middle GRIFFITH Last		4. DATE OF DEATH FEBRUARY Month 4 Day 19 Year 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/10/1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN H. GRIFFITH		14. MOTHER'S MAIDEN NAME CATHERINE BURGUR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-20-9895	
17. INFORMANT MRS. MARGARET BATEMAN		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General arteriosclerosis with cerebral thrombosis 334X DUE TO (b) 6-10 Mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverterculosis colon			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 1 , 19 60 , to Feb 4 , 19 60 , that I last saw the deceased alive on Feb. 4 , 19 60 , and that death occurred at 7:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 West Washington St. HAGERSTOWN MD. DATE SIGNED 2/6/60			
ACTUAL SIGNATURE Edward W. Ditto M.D.			
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/8/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2614

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02533

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAR LEITERSBURG</u>	c. LENGTH OF STAY IN 1b <u>10 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAPLEVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BROOK LANE FARM</u>		d. STREET ADDRESS <u>1 MAIN ST.</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JOHN H. GROSS</u>	First Middle Last	4. DATE OF DEATH <u>FEBRUARY - 17 - 1960</u>	Month Day Year
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST - 25 - 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	11. BIRTHPLACE (State or foreign country) <u>BENEVOLA WASH. CO. MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE E. GROSS</u>	
14. MOTHER'S MAIDEN NAME <u>SARAH E. MYERS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>218-07-7771</u>		17. INFORMANT <u>MRS. ANNA GROSS</u> Address <u>MAPLEVILLE MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation due to hanging</u> DUE TO (b) <u>hanging</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Approx 10 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Depressed Reaction</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Dittmann</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Dittmann, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 20 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>
22d. LOCATION (City, town, or county) <u>BOONSBORO WASH. CO. MD.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>		24a. REC'D BY REGISTRAR <u>FEB 23 60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>
ADDRESS <u>BOONSBORO MD.</u>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9812

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. MANNER OF DEATH</p> <p>14. SIGNATURE OF EXAMINER</p> <p>15. DATE OF EXAMINATION</p> <p>16. PLACE OF EXAMINATION</p> <p>17. SIGNATURE OF WITNESS</p> <p>18. DATE OF SIGNATURE</p> <p>19. PLACE OF SIGNATURE</p> <p>20. SIGNATURE OF JURY</p> <p>21. DATE OF JURY</p> <p>22. PLACE OF JURY</p> <p>23. SIGNATURE OF JURY</p> <p>24. DATE OF JURY</p> <p>25. PLACE OF JURY</p> <p>26. SIGNATURE OF JURY</p> <p>27. DATE OF JURY</p> <p>28. PLACE OF JURY</p> <p>29. SIGNATURE OF JURY</p> <p>30. DATE OF JURY</p> <p>31. PLACE OF JURY</p> <p>32. SIGNATURE OF JURY</p> <p>33. DATE OF JURY</p> <p>34. PLACE OF JURY</p> <p>35. SIGNATURE OF JURY</p> <p>36. DATE OF JURY</p> <p>37. PLACE OF JURY</p> <p>38. SIGNATURE OF JURY</p> <p>39. DATE OF JURY</p> <p>40. PLACE OF JURY</p> <p>41. SIGNATURE OF JURY</p> <p>42. DATE OF JURY</p> <p>43. PLACE OF JURY</p> <p>44. SIGNATURE OF JURY</p> <p>45. DATE OF JURY</p> <p>46. PLACE OF JURY</p> <p>47. SIGNATURE OF JURY</p> <p>48. DATE OF JURY</p> <p>49. PLACE OF JURY</p> <p>50. SIGNATURE OF JURY</p> <p>51. DATE OF JURY</p> <p>52. PLACE OF JURY</p> <p>53. SIGNATURE OF JURY</p> <p>54. DATE OF JURY</p> <p>55. PLACE OF JURY</p> <p>56. SIGNATURE OF JURY</p> <p>57. DATE OF JURY</p> <p>58. PLACE OF JURY</p> <p>59. SIGNATURE OF JURY</p> <p>60. DATE OF JURY</p> <p>61. PLACE OF JURY</p> <p>62. SIGNATURE OF JURY</p> <p>63. DATE OF JURY</p> <p>64. PLACE OF JURY</p> <p>65. SIGNATURE OF JURY</p> <p>66. DATE OF JURY</p> <p>67. PLACE OF JURY</p> <p>68. SIGNATURE OF JURY</p> <p>69. DATE OF JURY</p> <p>70. PLACE OF JURY</p> <p>71. SIGNATURE OF JURY</p> <p>72. DATE OF JURY</p> <p>73. PLACE OF JURY</p> <p>74. SIGNATURE OF JURY</p> <p>75. DATE OF JURY</p> <p>76. PLACE OF JURY</p> <p>77. SIGNATURE OF JURY</p> <p>78. DATE OF JURY</p> <p>79. PLACE OF JURY</p> <p>80. SIGNATURE OF JURY</p> <p>81. DATE OF JURY</p> <p>82. PLACE OF JURY</p> <p>83. SIGNATURE OF JURY</p> <p>84. DATE OF JURY</p> <p>85. PLACE OF JURY</p> <p>86. SIGNATURE OF JURY</p> <p>87. DATE OF JURY</p> <p>88. PLACE OF JURY</p> <p>89. SIGNATURE OF JURY</p> <p>90. DATE OF JURY</p> <p>91. PLACE OF JURY</p> <p>92. SIGNATURE OF JURY</p> <p>93. DATE OF JURY</p> <p>94. PLACE OF JURY</p> <p>95. SIGNATURE OF JURY</p> <p>96. DATE OF JURY</p> <p>97. PLACE OF JURY</p> <p>98. SIGNATURE OF JURY</p> <p>99. DATE OF JURY</p> <p>100. PLACE OF JURY</p>		<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. MANNER OF DEATH</p> <p>14. SIGNATURE OF EXAMINER</p> <p>15. DATE OF EXAMINATION</p> <p>16. PLACE OF EXAMINATION</p> <p>17. SIGNATURE OF WITNESS</p> <p>18. DATE OF SIGNATURE</p> <p>19. PLACE OF SIGNATURE</p> <p>20. SIGNATURE OF JURY</p> <p>21. DATE OF JURY</p> <p>22. PLACE OF JURY</p> <p>23. SIGNATURE OF JURY</p> <p>24. DATE OF JURY</p> <p>25. PLACE OF JURY</p> <p>26. SIGNATURE OF JURY</p> <p>27. DATE OF JURY</p> <p>28. PLACE OF JURY</p> <p>29. SIGNATURE OF JURY</p> <p>30. DATE OF JURY</p> <p>31. PLACE OF JURY</p> <p>32. SIGNATURE OF JURY</p> <p>33. DATE OF JURY</p> <p>34. PLACE OF JURY</p> <p>35. SIGNATURE OF JURY</p> <p>36. DATE OF JURY</p> <p>37. PLACE OF JURY</p> <p>38. SIGNATURE OF JURY</p> <p>39. DATE OF JURY</p> <p>40. PLACE OF JURY</p> <p>41. SIGNATURE OF JURY</p> <p>42. DATE OF JURY</p> <p>43. PLACE OF JURY</p> <p>44. SIGNATURE OF JURY</p> <p>45. DATE OF JURY</p> <p>46. PLACE OF JURY</p> <p>47. SIGNATURE OF JURY</p> <p>48. DATE OF JURY</p> <p>49. PLACE OF JURY</p> <p>50. SIGNATURE OF JURY</p> <p>51. DATE OF JURY</p> <p>52. PLACE OF JURY</p> <p>53. 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PLACE OF JURY</p> <p>92. SIGNATURE OF JURY</p> <p>93. DATE OF JURY</p> <p>94. PLACE OF JURY</p> <p>95. SIGNATURE OF JURY</p> <p>96. DATE OF JURY</p> <p>97. PLACE OF JURY</p> <p>98. SIGNATURE OF JURY</p> <p>99. DATE OF JURY</p> <p>100. PLACE OF JURY</p>
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CERTIFICATE OF DEATH

Reg. Dist. No.

02534

2533

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
c. LENGTH OF STAY IN 1b 36 years		d. STREET ADDRESS 111 East Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elva Middle Viola Last Grove		4. DATE OF DEATH Month February Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1888
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Big Spring Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Lewis Dougherty		14. MOTHER'S MAIDEN NAME Laura Shank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give nbr or dates of service) none	
INFORMANT Guy M. Grove		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) upper Respiratory Infection			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1948 , to Feb 9, 1960 , that I last saw the deceased alive on Feb 9, 1960 , and that death occurred at 9:10 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert V. H. Campbell		DATE SIGNED 2/12/60	
PHYSICIAN'S NAME (Type) Robert V. H. Campbell		Hagerstown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-60	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Near Clearspring Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR Hagerstown Md.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE FEB 15 '60	

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2232

Washington

Washington

Washington

Washington

30 years

Washington

111 East Ave.

Washington County Hospital

9-50

February

Grove

Villa

Have

Feb. 23, 1933

Female, white

Big Spring, Md.

Own home

White

Large blank

Female - non-English

no.

Washington

Gay M. Grove

born

no

Health Officer

Dr. F. L. Gentry

1-11-33

Dr. F. L. Gentry & Son, Dr. F. L. Gentry

2603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 8 mos 2 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>William</u> Last <u>Grove</u>		4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 23, 1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Ice Cream Mfg.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sharpsburg, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Daniel Phillip Grove</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Snively</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Glomerulonephritis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis + Early Congestive</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>Feb 1</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Jan 27</u> , 19 <u>60</u> , and that death occurred at <u>8:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Byrkit</u> M.D. <u>28 W Potomac</u>		DATE SIGNED <u>2-2-60</u>	
PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		<u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro Franklin, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hare</u> ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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090

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2003

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

OFFICE OF THE REGISTRAR

STATE OF MARYLAND

COUNTY OF BALTIMORE

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2534

CERTIFICATE OF DEATH

Reg. Dist. No.

02536

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Grove 75-x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>Shady Grove, Pa.</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>B.</u> Middle <u>GROVE</u> Last		4. DATE OF DEATH <u>Feb.</u> Month <u>11</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/1893</u>
9. AGE (In years last birthday) <u>66</u> ym.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Lovell</u>	
14. MOTHER'S MAIDEN NAME <u>Sadie Spangler</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Frank Speelman - Greencastle, Pa.</u> Address <u>RD3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>422.1 HEMO AND <u>Arteriosclerotic Cardiovascular disease</u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstructive hepatitis due to stasis of circulation due to</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1939</u> , to <u>2/11/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/11/60</u> , 19 <u>60</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u> DATE SIGNED <u>Feb 15 '60</u>			
ACTUAL SIGNATURE <u>W.C. Brewer</u> M.D.		PHYSICIAN'S NAME (Type) <u>W.C. Brewer</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munnich - Greencastle, Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 15 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Orlando S. Hanna</u>

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>WILLIAM A. KIRBY</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>68</u></p>	
<p>4. Date of death: <u>April 10, 1914</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart failure</u></p>	
<p>7. Date of burial: <u>April 12, 1914</u></p>	
<p>8. Place of burial: <u>St. John's Cemetery</u></p>	
<p>9. Name of funeral home: <u>St. John's</u></p>	
<p>10. Name of physician: <u>Dr. J. H. Smith</u></p>	
<p>11. Name of undertaker: <u>St. John's</u></p>	
<p>12. Name of registrar: <u>St. John's</u></p>	
<p>13. Name of witness: <u>St. John's</u></p>	
<p>14. Name of witness: <u>St. John's</u></p>	
<p>15. Name of witness: <u>St. John's</u></p>	
<p>16. Name of witness: <u>St. John's</u></p>	
<p>17. Name of witness: <u>St. John's</u></p>	
<p>18. Name of witness: <u>St. John's</u></p>	
<p>19. Name of witness: <u>St. John's</u></p>	
<p>20. Name of witness: <u>St. John's</u></p>	
<p>21. Name of witness: <u>St. John's</u></p>	
<p>22. Name of witness: <u>St. John's</u></p>	
<p>23. Name of witness: <u>St. John's</u></p>	
<p>24. Name of witness: <u>St. John's</u></p>	
<p>25. Name of witness: <u>St. John's</u></p>	
<p>26. Name of witness: <u>St. John's</u></p>	
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<p>28. Name of witness: <u>St. John's</u></p>	
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<p>33. Name of witness: <u>St. John's</u></p>	
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<p>50. Name of witness: <u>St. John's</u></p>	
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<p>79. Name of witness: <u>St. John's</u></p>	
<p>80. Name of witness: <u>St. John's</u></p>	
<p>81. Name of witness: <u>St. John's</u></p>	
<p>82. Name of witness: <u>St. John's</u></p>	
<p>83. Name of witness: <u>St. John's</u></p>	
<p>84. Name of witness: <u>St. John's</u></p>	
<p>85. Name of witness: <u>St. John's</u></p>	
<p>86. Name of witness: <u>St. John's</u></p>	
<p>87. Name of witness: <u>St. John's</u></p>	
<p>88. Name of witness: <u>St. John's</u></p>	
<p>89. Name of witness: <u>St. John's</u></p>	
<p>90. Name of witness: <u>St. John's</u></p>	
<p>91. Name of witness: <u>St. John's</u></p>	
<p>92. Name of witness: <u>St. John's</u></p>	
<p>93. Name of witness: <u>St. John's</u></p>	
<p>94. Name of witness: <u>St. John's</u></p>	
<p>95. Name of witness: <u>St. John's</u></p>	
<p>96. Name of witness: <u>St. John's</u></p>	
<p>97. Name of witness: <u>St. John's</u></p>	
<p>98. Name of witness: <u>St. John's</u></p>	
<p>99. Name of witness: <u>St. John's</u></p>	
<p>100. Name of witness: <u>St. John's</u></p>	

2535

02537

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Conv. Home</u>				1. d. STREET ADDRESS <u>139 High St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSIE FLORENCE HAMBY</u>				4. DATE OF DEATH Month Day Year <u>Feby 19 1960 19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21 1884</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa., Welsh Run Franklin Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John pingaman</u>				14. MOTHER'S MAIDEN NAME <u>Alice O. Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Mrs Annie Bartles Maugansville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cerebral arteriosclerotic Heart Dis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>6 yrs</u> <u>3 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-18-60</u> , 19 <u>60</u> , to <u>2-19-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-18-60</u> , 19 <u>60</u> , and that death occurred at <u>1:50 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. E. W. H. T. J.</u>		M.D. <u>Hagerstown Md</u>		ADDRESS (Street, city or town, state) <u>139 High St</u>		DATE SIGNED <u>2/23/60</u>	
PHYSICIAN'S NAME (Type) <u>A. E. W. H. T. J.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IS INDICATED BY THE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2615

CERTIFICATE OF DEATH

02538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Berkeley ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN lb 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nealie Middle A. Last Harrison		4. DATE OF DEATH Month Feb. Day 23 , Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 4 Days 8	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Berkeley Co. W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Landis		14. MOTHER'S MAIDEN NAME Laura Horner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Martinsburg W.Va. P.L. Sharff 233 N. Tenn. Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Generalized arteriosclerosis & Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized chronic Arthritis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 hour years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 21, 1960 to Feb. 23, 1960 that I last saw the deceased alive on Feb. 21, 1960 , and that death occurred at 12:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B.M. Schindler M.D.		ADDRESS (Street, city or town, state) 43 Greene St. Cumberland, Md. DATE SIGNED 2-24-60	
PHYSICIAN'S NAME (Type) B.M. Schindler, M.D.		43 Greene Street, Cumberland, Md. 2-24-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/60	
22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Shanghai W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		ADDRESS Martinsburg W.Va.	
24a. REC'D BY REGISTRAR FEB 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kiser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2536

CERTIFICATE OF DEATH

02539

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN TB <u>7 wks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harlock Nursing Home</u>		d. STREET ADDRESS <u>727 Holliston St.</u>	
3. NAME OF DECEASED (Type or print) First <u>W.</u> Middle <u>Bruce</u> Last <u>Hawbaker</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Payroll Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George B. Hawbaker</u>		14. MOTHER'S MAIDEN NAME <u>Charissa Ziegler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>76-09-9440</u>	
17. INFORMANT <u>Mrs. W. Bruce Hawbaker</u>		Address <u>Greencastle Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Hemorrhage</u> DUE TO (c) <u>6 mm</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hr</u> <u>6 mm</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-1-</u> , 19 <u>60</u> , to <u>2-13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-11-60</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Duff</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>2/13/60</u>	
PHYSICIAN'S NAME (Type) <u>DREW J. T. O'G</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Winnick</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 18 '60</u>	
ADDRESS <u>Greencastle</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02540

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonesboro		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeders Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Florence Last Hebb		4. DATE OF DEATH Month February Day 29 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 77 yrs.
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lewis Beard		14. MOTHER'S MAIDEN NAME Susan Harbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-32-5517	
17. INFORMANT Chester I. Hebb		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 1960 to Feb. 29, 1960 , that I last saw the deceased alive on February 28, 1960 , and that death occurred at 8 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Lellan M.D.		ADDRESS (Street, city or town, state) Boonesboro Md.	
PHYSICIAN'S NAME (Type) G. W. Lellan		DATE SIGNED 3/2/60 md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR MAR 7 '60	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Item 18 Film 250 3-11-60 ams 2537 Item 4 Film G257 2-26-60 et										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 15 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 41 Fairground Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					02541	
3. NAME OF DECEASED (Type or print) First ALMA Middle ELISE Last HIGGS			4. DATE OF DEATH Month Feb. Day 16, Year 1960								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1886		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Art Dealer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York, N.Y.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Wallerman					14. MOTHER'S MAIDEN NAME Mary Fitzpatrick						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT David Thayer			Address 41 Fairground Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration vomitus 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerosis (c) Fatty change in liver (fatty metamorphosis) DUE TO cause lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE Edward W. Dittus III M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 2/18/60			
EXAMINER'S NAME (Type) Edward W. Dittus III, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral 1 Chapel Inc. Hagerstown, Md.					ADDRESS Wm. C. Howt			24a. REC'D BY REGISTRAR FEB 20 1960		24b. REGISTRAR'S SIGNATURE Charles E. F...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2538

CERTIFICATE OF DEATH

Reg. Dist. No.

02542

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1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PA.</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MERCERSBURG, PA. 75 X-3</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>111 W. SEMINARY ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>EDGAR</u> Last <u>HIGHLANDS</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> , 1960 Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/21/1890</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	11. BIRTHPLACE (State or foreign country) <u>Shippensburg, Pa. R.D.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry H. Highlands</u>	
14. MOTHER'S MAIDEN NAME <u>Ida M. Angle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>179-12-4997</u>		17. INFORMANT Address <u>Pa. Miss Kathryn Highlands, Mercersburg,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>60</u> , to <u>2/6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/6</u> , 19 <u>60</u> , and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Storn Baker</u> M.D. <u>154 W. Washington St.</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>2-8-60</u>		PHYSICIAN'S NAME (Type) <u>DR. JOHN H. STORNBAKER</u> <u>Stagerstown - Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Mercersburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. Sminger</u> ADDRESS <u>Mercersburg, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 10 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

1529

1992

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

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2616
CERTIFICATE OF DEATH

Reg. Dist. No.

02543

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>Franklin</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocahontas</u> 75X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Menonite Home, Magesville</u>				d. STREET ADDRESS <u>West Madison St</u>			
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>D</u> Last <u>Hilscher</u>				4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1872</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmith</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unable to obtain</u>				14. MOTHER'S MAIDEN NAME <u>Unable to obtain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Robert L. Davis RD # Hagerstown, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial degeneration and</u> <u>443X</u> DUE TO <u>decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis, hypertensive</u> DUE TO <u>cardio-vascular disease</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>51</u> , to <u>2-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>60</u> , and that death occurred at <u>p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Guenon</u>				ADDRESS (Street, city or town, state) <u>25 W. Baltimore St</u> DATE SIGNED <u>2-18-60</u>			
PHYSICIAN'S NAME (Type) <u>William A. GUENON</u>				<u>Greencastle, Penna</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley M. Zimmerman</u>				ADDRESS <u>Greencastle Pa</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kirsch</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH BALTIMORE		PLACE OF DEATH BALTIMORE	
STREET AND NUMBER 1234 E. BALTIMORE ST.		STREET AND NUMBER 1234 E. BALTIMORE ST.	
CITY OR TOWN BALTIMORE		CITY OR TOWN BALTIMORE	
STATE MARYLAND		STATE MARYLAND	
NAME OF DECEASED JOHN DOE		NAME OF DECEASED JOHN DOE	
SEX MALE		SEX MALE	
AGE 45		AGE 45	
OCCUPATION DOCTOR		OCCUPATION DOCTOR	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 15 1950		DATE OF DEATH JAN 15 1950	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
PLACE OF DEATH HOME		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED (None)		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESS (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF CLERK (None)	

This certificate is to be filled out by the physician or other person who has attended the deceased at the time of death. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

The information furnished on this certificate is for the purpose of compiling statistics and for the purpose of determining the cause of death. It is not to be used for any other purpose.

The information furnished on this certificate is for the purpose of compiling statistics and for the purpose of determining the cause of death. It is not to be used for any other purpose.

CERTIFICATE OF DEATH

Reg. Dist. No.

02544

2539

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 924 Chestnut St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel First Linnaeus Middle Hoover Last		4. DATE OF DEATH Month February Day 3 Year 60	
5. SEX amel	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1867
9. AGE (In years and birthday) yrs. 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY veteran bureau	
11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W. Hoover		14. MOTHER'S MAIDEN NAME Sarah A. M. Oswald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no If yes, give war or dates of service		16. SOCIAL SECURITY NO. none	
17. INFORMANT John Williams, RFD, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x DUE TO Carcinoma Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General atherosclerosis DUE TO (c) General atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1-59 , to 2-3-60 , that I last saw the deceased alive on 2-2-60 , 19, and that death occurred at 9 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. W. Ditty		ADDRESS (Street, city or town, state) DATE SIGNED 7/6/60	
PHYSICIAN'S NAME (Type) E. W. Ditty		M.D. Arthur L. Kraus	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-6-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clarence Carty, Frederick, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE FEB 8 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

Wash.

Mo.

Washington

Washington

10 years

Washington

924 Chestnut St.

924 Chestnut St.

February 3, 1900

Hoover

Linnane

Samuel

June 2, 1887

White

White

Frederick Co., Md.

Clark

Sarah A. M. Oswald

John W. Hoover

John Williams, H.P., Washington, Mo.

None

None

Frederick, Md.

Frederick, Md.

Frederick, Md.

Frederick, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2540

CERTIFICATE OF DEATH

Reg. Dist. No.

02545
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>36 Yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>70 East Ave</u>			d. STREET ADDRESS <u>70 East Ave</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE McCLELLAND HORNBAKER</u>			4. DATE OF DEATH Month Day Year <u>Feb 16 1960</u> <u>19</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17 1883</u>	9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Zachariah Hornbaker</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Carbaugh</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----	INFORMANT Address <u>Mrs Clara Hornbaker 70 East Ave</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0 Viral pneumonia</u> (b) <u>tuberculosis, inactive</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 15, 1960</u> , to <u>Feb 16, 1960</u> , that I last saw the deceased alive on <u>Feb 16, 1960</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 West Washington Street 2/17/60</u>					
ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D.		DATE SIGNED <u>2/17/60</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D. Hagerstown, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>			ADDRESS <u>Hagerstown Md.</u>	24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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DEPT. OF HEALTH

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1900

JAN 10

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1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02546

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN 1b 51 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 43 S. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Margaret Last Houck		4. DATE OF DEATH Month Feb. Day 27 , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1864
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY private homes	
11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Houck		14. MOTHER'S MAIDEN NAME Lucindia Shank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT J. Ralph Murray, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation (Smoke) 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3rd + 4th deg Burns of Head & legs DUE TO (c) instant			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Evidently dress caught fire from stove			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned & death in own home	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2-27 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Smithsburg Washington Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE A. E. Duth		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. E. W. J. T. O. H.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF 2-29-60		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	
22d. LOCATION (City, town, or county) (State) Smithsburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR MAR 1 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2541

CERTIFICATE OF DEATH

Reg. Dist. No.

02547
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>1 Week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY ELLEN HOUSE</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 7 1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jerry Provard</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Grams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Glenn R. Wishard</u>				Address <u>746 W. Washington St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1947</u> , 19 <u> </u> to <u>2/15/60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2/15/60</u> , 19 <u> </u> , and that death occurred at <u>245 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 M. Potomac St HAGERSTOWN, MD</u> DATE SIGNED <u>2/16/60</u> ACTUAL SIGNATURE <u>S. Earl Young</u> M.D. PHYSICIAN'S NAME (Type) <u>S. EARL YOUNG M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>2/17/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash Co Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knoch</u>							

CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2542

CERTIFICATE OF DEATH

Reg. Dist. No. 302

02548

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle GARFIELD Last KEEDY				4. DATE OF DEATH Month February Day 11 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 8, 1882	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk		10b. KIND OF BUSINESS OR INDUSTRY County Tax Office		11. BIRTHPLACE (State or foreign country) near Keedysville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josephus C. Keedy				14. MOTHER'S MAIDEN NAME Martha A. Keefhauer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Mrs. Mae K. Baker Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Aortic Aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Vasc. disease DUE TO (c) Arteriosclerosis - general.						INTERVAL BETWEEN ONSET AND DEATH 3 mo. 4 yrs. 4 yrs. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from April, 1954 to Feb. 11, 1960 , that I last saw the deceased alive on Feb. 6, 1960 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2111/60 214 N. Potomac St. DATE SIGNED 2/12/60 ACTUAL SIGNATURE Lloyd A. Hoffman M.D. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/13/1960	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Meyer		ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR FEB 15 60	24b. REGISTRAR'S SIGNATURE Arthur S. Knaus		

090

MEDICAL CERTIFICATION

STATEMENT OF DEATH

1902

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 02549									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN lb 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1709 Sherman Ave.					d. STREET ADDRESS 1709 Sherman Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cyrus Middle Clement Last Kershner					4. DATE OF DEATH Month Feb. Day 6 Year 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 5 1895		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Marlowe W. Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME David Clement Kershner					14. MOTHER'S MAIDEN NAME Laura E. Trout				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219 14 7588		17. INFORMANT Mrs. Beryl Kershner Address 1709 Sherman Ave. Hagerstown Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Dislocation of Cervical spine C1-9 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c) Chronic Bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH instant 10 yrs 10 yrs									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Evidently fell down cellar steps fracturing cervical vertebrae.					
20c. TIME OF INJURY Month, Day, Year Hour 12:30 p.m. Feb. 6, 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hagerstown		(County) Wash (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE A. S. Smith M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. E. W. J. T. To J.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9-60		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery			22d. LOCATION (City, town, or county) (State) Williamsport Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport Md					24a. REC'D BY REGISTRAR FEB 10 '60		24b. REGISTRAR'S SIGNATURE Charles E. Kneass		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF _____ CITY OF _____		DEPARTMENT OF HEALTH BALTIMORE, MARYLAND	
NAME OF DECEASED _____ SEX _____ AGE _____		OCCUPATION _____ PLACE OF BIRTH _____	
DATE OF DEATH _____ TIME OF DEATH _____		PLACE OF DEATH _____ CAUSE OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____ TITLE _____		SIGNATURE OF CORONER _____ TITLE _____	
SIGNATURE OF WITNESS _____ TITLE _____		SIGNATURE OF WITNESS _____ TITLE _____	

2618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. Va. b. COUNTY Berkeley ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg 85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		d. STREET ADDRESS 219 N. Church St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Solie Middle F Last Kline		4. DATE OF DEATH Month February Day 6 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1892 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retiree		10b. KIND OF BUSINESS OR INDUSTRY Mill Worker	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Kline		14. MOTHER'S MAIDEN NAME Annie E. Watson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Edward Kline		Address Falling Waters W. Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mo.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Aug 5, 1959 to Feb 6, 1960 , that I last saw the deceased alive on Feb 5, 1960 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer		ADDRESS (Street, city or town, state) Box 206 DATE SIGNED 2/8/60	
PHYSICIAN'S NAME (Type) David R. Brewer		Clear Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/9/60	22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	22d. LOCATION (City, town, or county) Martinsburg (State) W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		24. REC'D BY REGISTRAR W. Va. DATE FEB 15 60	
25. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2544 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>18 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				d. STREET ADDRESS <u>413 Edgewood Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET DELLINGER KRETSINGER</u>				4. DATE OF DEATH Month Day Year <u>Feby 3 1960 19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3 1882</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Downsville Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cyrus Dellinger</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Winters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-18-7717</u>		INFORMANT Address <u>Mrs Edna Hill 413 Edgewood Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>7 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1-49</u> , 19 <u>49</u> , to <u>2/3/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/3/60</u> , 19 <u>60</u> , and that death occurred at <u>6:10 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Searl Young</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>148 M. Potomac St. Hagerstown Md. 2/4/60</u>					
PHYSICIAN'S NAME (Type) <u>SEARL YOUNG</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hantz</u>			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2545 **CERTIFICATE OF DEATH**

02552

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND. b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b FIVE WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL				d. STREET ADDRESS 101 SOUTH POTOMAC ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE ANN LAMAR				4. DATE OF DEATH Month Day Year FEBRUARY - 24 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER - 8 - 1892		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 4 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY DEPARTMENT STORE		11. BIRTHPLACE (State or foreign country) BOONSBORO WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT LAMAR				14. MOTHER'S MAIDEN NAME NELLIE EAKLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. 214-09-7634		17. INFORMANT MRS. MAXWELL YINGLING Address 500 G. ROVE AVE. HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of Abdomen 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of the Colon DUE TO (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1955 to Feb. 24, 1960 that (I) (we) last saw the deceased alive on Feb. 24, 1960 and that death occurred 1/24/60 from the causes and on the date stated above.							
22a. SIGNATURE L. L. Parker Jr				22b. DATE SIGNED 2/26/60		22c. PHYSICIAN'S NAME (Type) L. L. Parker Jr	
22d. ADDRESS				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 27, 1960		23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		23d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John A. Best ADDRESS BOONSBORO MD.				25a. REC'D BY REGISTRAR DATE MAR 1 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. Parker
145 W. Wash. St.
Hagerstown Md.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02553

2546

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 50YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL First CLATON Middle LEITER SR. Last		4. DATE OF DEATH FEBRUARY Month 8 Day 19 Year 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GROCER		10b. KIND OF BUSINESS OR INDUSTRY OWN STORE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWIN C. LEITER		14. MOTHER'S MAIDEN NAME ELIZABETH LEHMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, NO unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 217-12-1770A INFORMANT MRS. EDNA M. LEITER Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 492X IMMEDIATE CAUSE (a) DUE TO Virus pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Laenne's Cough			INTERVAL BETWEEN ONSET AND DEATH 1 WK
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-2-60 , 19 60 , to 2-8-60 , 19 60 , that I last saw the deceased alive on 2-8-60 , 19 60 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 318 N. Potomac St. Hagerstown, Md. DATE SIGNED 2-9-60			
ACTUAL SIGNATURE Paul Harrison		M.D. 318 N. Potomac St. Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Paul Harrison, M. D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL	22b. DATE THEREOF 2/11/60	22c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Harrison, Hagerstown, Md.		24a. RECEIVED BY REGISTRAR FEB 12 '60 DATE	
		24b. REGISTRAR'S SIGNATURE Charles L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2619

02554

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVER CREEK - RURAL				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOONSBORO MD. R.I.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WALTER FRANK LIZER				4. DATE OF DEATH FEBRUARY - 25 - 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JULY - 17 - 1894	
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 7 Days 8		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOBACCO ORGAN FACTORY M.P. MILLER, MYERSVILLE FRED. CO. MD. U.S.A.				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME WALTER LIZER				14. MOTHER'S MAIDEN NAME ESTIE SHEPLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-09-1608		17. INFORMANT MRS. VERNIE LIZER BOONSBORO MD. R.I. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) CORONARY ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
INTERVAL BETWEEN ONSET AND DEATH 10 minutes 1 YEAR							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-2-60 to death 19 , that (I) (we) last saw the deceased alive on 2-24-60 19 , and that death occurred at 5 PM from the causes and on the date stated above.							
22a. SIGNATURE Paul Harrison				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.				22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF FEB. 28 - 1960			
23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY				23d. LOCATION (City, town, or county) (State) BOONSBORO WASH. Co. MD.			
24. FUNERAL DIRECTOR'S SIGNATURE John D. Bait				25a. REC'D BY REGISTRAR DATE MAR 1 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. Frank							

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2547

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FANNIE Middle MAIPHURS Last MAIPHURS				4. DATE OF DEATH Month February Day 6 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1867	
9. AGE (In years lost birthday) 92 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chewsville, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Colliflower				14. MOTHER'S MAIDEN NAME Elizabeth A. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none			
17. INFORMANT Rev. Bernard Jennings				Address Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Polmonary Fibrosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 Hr. 10 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-17 , 19 50 , to 2-6 , 19 60 , that I last saw the deceased alive on 2-5 , 19 60 , and that death occurred at 11:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 2-8-60							
ACTUAL SIGNATURE Charles E. Hess M.D.							
PHYSICIAN'S NAME (Type) Smithsburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1966		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rouse				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE FEB 13 1960	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 4 Film G257 3-2-60 et
CERTIFICATE OF DEATH

02556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Penn Mar</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Com. Home</u>		d. STREET ADDRESS <u>Oak St.</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>L.</u> Middle <u>Manahan</u> Last		4. DATE OF DEATH <u>Feb.</u> Month <u>22</u> Day <u>1960</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 29, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Fountaindale, Adams Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sprinkle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Buckingham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Charles H. Manahan</u> Address <u>Pen Mar, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbuncle of back</u> <u>690.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epileptiform Convulsions</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 19, 1956</u> to <u>Feb 22, 1960</u> , that I last saw the deceased alive on <u>Feb. 22, 1960</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>2/24/60</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/25/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hove</u> ADDRESS <u>Hagerstown, Pa.</u>		24a. REC'D BY REGISTRAR <u>FEB 29 1960</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

2548

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRVING Middle CLYDE Last MARTIN		4. DATE OF DEATH Month February Day 16 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1873
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Frt. Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Victor, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Martin		14. MOTHER'S MAIDEN NAME Mary Ellen Manatt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 708-07-2486	
17. INFORMANT Mrs. Nelle O. Martin		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease & failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic Recurrent Bronchial asthma INTERVAL BETWEEN ONSET AND DEATH 3 wks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 6 , 19 60 , to Feb 16 , 19 60 , that I last saw the deceased alive on Feb 16 , 19 60 , and that death occurred at 2 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 W Washington ST Hagerstown Md DATE SIGNED 2/17/60 ACTUAL SIGNATURE Robert V. H. Campbell M.D. PHYSICIAN'S NAME (Type) Robert V. H. Campbell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Ringer		24a. REC'D BY REGISTRAR FEB 23 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>West Virginia</u> b. COUNTY <u>Morgan</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkeley Springs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Nursing Home</u>		d. STREET ADDRESS <u>85X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>J.</u> Last <u>Mason</u>		4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lee Mason</u>		14. MOTHER'S MAIDEN NAME <u>Susan Burton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>236-03-7611</u>	
17. INFORMANT <u>Mr. Elmer Mason</u>		Address <u>Berkeley Springs, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1-20</u> , 19 <u>59</u> , to <u>7-12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-11-60</u> , 19____, and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. E. Smith</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>7/13/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. J. P. G.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Primitive Baptist Frederick Co. Md.</u>	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Norman</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Robert S. Tharr</u>		24b. REGISTRAR'S SIGNATURE _____	
DATE <u>FEB 23 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/5/29		5. PLACE OF BIRTH MOBILE, ALA.		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION High School		11. PRESENT ADDRESS 2510 E. MONROE ST., BALTIMORE, MD.		12. DATE OF DEATH 4/4/68	
13. CAUSE OF DEATH Suicide by gunshot		14. MANNER OF DEATH Homicide		15. PLACE OF DEATH Baltimore, Md.		16. TIME OF DEATH 11:00 AM		17. PHYSICIAN'S SIGNATURE (Signature)		18. COUNTY Baltimore	
19. MEDICAL HISTORY None		20. PRESENT ILLNESS None		21. PREVIOUS ILLNESSES None		22. SURGICAL HISTORY None		23. MEDICATIONS None		24. ALCOHOLIC HISTORY None	
25. TOXICOLOGICAL HISTORY None		26. SOCIAL HISTORY None		27. PERSONAL HISTORY None		28. FAMILY HISTORY None		29. OTHER HISTORY None		30. SIGNATURE OF REGISTRAR (Signature)	

MAY 1968

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the county in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2549

CERTIFICATE OF DEATH

Reg. Dist. No.

02559

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>15 min.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown RFD #4</u>		d. STREET ADDRESS <u>Cosytown Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stuart</u> Middle <u>Hilson</u> Last <u>Mason</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>Berkeley Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abram Mason</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Kees</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219 20 0931</u>	
INFORMANT <u>Mrs. Mary Ellen Mason Md. RFD #4</u>		17. PLACE OF DEATH <u>Cosytown Rd. Hagerstown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>general arteriosclerosis</u> and (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>5 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign prostatic hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 20, 1957</u> , to <u>Feb 20, 1960</u> , that I last saw the deceased alive on <u>Feb 20, 1960</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>212 W. Washington St Hagerstown Md.</u> DATE SIGNED <u>2/22/60</u>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D. Hagerstown Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 24-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

CERTIFICATE OF DEATH

1924

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Age: _____</p>		<p>4. Date of birth: _____</p>	
<p>5. Place of birth: _____</p>		<p>6. Date of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Place of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. DR. SECONDARI

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02560

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>9 HOURS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES LEON METZ</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY - 11 - 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH - 24 - 1915</u>
9. AGE (In years lost birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours <u>10 17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOLLER ORGAN CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHESTNUT GROVE WASH. CO. MD. U.S.A.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES METZ</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN JAMISON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-16-1169</u>	
17. INFORMANT <u>MRS. BLANCHE METZ</u>		Address <u>KEEDYSVILLE MD. R.I.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> 19 <u>60</u> , to <u>2/11</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> 19 <u>60</u> , and that death occurred at <u>9:10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Secondari</u>		22b. DATE SIGNED <u>2/13/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari, M. D.</u>		22d. ADDRESS <u>Boonsboro, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 14, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SAMPLES MANOR CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SAMPLES MANOR WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 18 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

CONFIDENTIAL

[Faint, mostly illegible text covering the majority of the page, appearing to be a memorandum or report.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2551

CERTIFICATE OF DEATH

Reg. Dist. No.

02561

1. PLACE OF DEATH o. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b. 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 534 Summit Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carrie Middle Christina Last Miller				4. DATE OF DEATH Month Feb. Day 25 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75		IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min. 75			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Ft. Loudon, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Divelbiss				14. MOTHER'S MAIDEN NAME Mary Tritle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 204-01-4116		17. INFORMANT Mrs. D.C. Fields, 534 Summit Ave. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis DUE TO (c) 1 wk						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease; Adenocarcinoma Breast						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 16, 1960 to Feb 25, 1960 , that I last saw the deceased alive on Feb 25, 1960 , and that death occurred at 3:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED Feb 26, 1960							
ACTUAL SIGNATURE Richard V. Hawver		PHYSICIAN'S NAME (Type) RICHARD V. HAWVER 247 No. Potomac St.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/28/60		22c. NAME OF CEMETERY OR CREMATORY Stenger Hill Cem.		22d. LOCATION (City, town, or county) (State) Ft. Loudon, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. G. Gummer ADDRESS Mercersburg, Pa.				24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2599

02562

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. LENGTH OF STAY IN 1b <u>30 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 S. MAIN ST.</u>				d. STREET ADDRESS <u>118 S. MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD EMORY MILLER</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY - 6 - 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST - 11 - 1901</u>	
9. AGE (In years lost birthday) <u>58 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>5 25</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHEET METAL WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FAIRCHILD AIRCRAFT MT. CARMEL WASH. CO. MD.</u>			
13. FATHER'S NAME <u>SILAS MILLER</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE FLOK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>214-09-9700</u>			
17. INFORMANT <u>MRS. ALMA MILLER</u>				Address <u>BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Coronary thrombosis</u> DUE TO <u>Artero-sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Artero-sclerotic heart disease</u> DUE TO (c) <u>Artero-sclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year -</u> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred at <u>6 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>21 N. Main St., Boonsboro, Md.</u> DATE SIGNED <u>Joseph Secondary</u>							
ACTUAL SIGNATURE <u>Joseph Secondary</u>				M.D. <u>21 N. Main St., Boonsboro, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>				<u>BOONSBORO MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 9. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Dyer</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Manner of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Date of registration: _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02563

2552

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>424 Brewer Ave.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>424 Brewer Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Wesley Miller</u>		4. DATE OF DEATH Month Day Year <u>Feb. 16 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 27, 1887</u>
9. AGE (In years last birthday) <u>72 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u>	11. BIRTHPLACE (State or foreign country) <u>Foltz, Franklin Cty., Pa. U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John W. Miller</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Jones</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>209-07-6316</u>		INFORMANT <u>Mrs. Rosetta Miller, 424 Brewer Ave Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cardiovascular collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> (c) <u>Coronary Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral vas. accident - M. age (6)</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/16/60</u> to <u>2/16/60</u> , that I last saw the deceased alive on <u>2/16</u> , 19 <u>60</u> , and that death occurred at <u>M. from the causes and on the date stated above.</u> ADDRESS (Street, city or town, state) <u>119 E. Antietam</u> DATE SIGNED <u>2/17/60</u> ACTUAL SIGNATURE <u>Louis G. Graff</u> M.D. <u>Hagerstown</u> PHYSICIAN'S NAME (Type) <u>Louis G. Graff</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Gardens Hagerstown Wash. Cty., Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>FEB 23 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

2523

MASSACHUSETTS

1. Name of deceased: John J. Smith
2. Sex: Male
3. Age: 65
4. Date of death: 10/15/1911
5. Place of death: Home
6. Cause of death: Heart failure
7. Signature of physician: [Signature]
8. Signature of registrar: [Signature]
9. Date of registration: 10/16/1911

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 2553
 CERTIFICATE OF DEATH

02564

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 29 N. Locust St.,			d. STREET ADDRESS 1 29 N. Locust St.,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Samuel Middle T Last Moore			4. DATE OF DEATH Month 2 Day 9 Year 19 60		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1872		9. AGE (In years last birthday) yrs. 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired roadman		10b. KIND OF BUSINESS OR INDUSTRY M.P. Moller Co.		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-05-2370		17. INFORMANT Raymond M McAfee Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis due to 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) 2 yrs.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Epithelial Carcinoma base of pharynx. ② Virus Influenza					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1, 1959 to Feb 9, 1960 , that (I) (we) last saw the deceased alive on Feb 2, 1960 , and that death occurred at 4 PM , from the causes and on the date stated above.					
22a. SIGNATURE Edward W. Ditto III			22b. DATE SIGNED 2/10/60		
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.			22d. ADDRESS 217 West Washington Street		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-11-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
		23d. LOCATION (City, town, or county) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss			25a. REC'D BY REGISTRAR FEB 12 '60		
ADDRESS Hagerstown, Md.			25b. REGISTRAR'S SIGNATURE William S. Thomas		

WEST VIRGINIA DEPARTMENT OF HEALTH
A DIVISION OF THE STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

255

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Date of registration: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN lb 15 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Andrew Last Myers		4. DATE OF DEATH Month Feb. Day 17 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13 1891
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 1 Days 2 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Molder (Ret'd)		10b. KIND OF BUSINESS OR INDUSTRY Brick Yard	
11. BIRTHPLACE (State or foreign country) Mercersburg Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles A. Myers		14. MOTHER'S MAIDEN NAME Ella Byers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216 07 1227	
17. ADDRESS 15 E. Fenton Ave. Williamsport Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 260X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Diabetes Mellitus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 years. 10 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1934 , 19____, to 2/17/60 , 19____, that I last saw the deceased alive on 2/16/60 , 19____, and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 N. Potomac St., Hagerstown, Md. DATE SIGNED 2/19/60			
ACTUAL SIGNATURE S. Earl Young M.D.		PHYSICIAN'S NAME (Type) S. Earl Young M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 20-60	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Lef Williamsport, Md		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
24b. REGISTRAR'S SIGNATURE Charles S. King			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2222

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

2557

CERTIFICATE OF DEATH

Reg. Dist. No.

02568

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 20, 1882</u>	
9. AGE (In years lost birthday) <u>77 yrs.</u>		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		11. IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		12. CITIZEN OF WHAT COUNTRY? <u>near Hagerstown, Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>			
11. BIRTHPLACE (State or foreign country) <u>near Hagerstown, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>near Hagerstown, Md.</u>			
13. FATHER'S NAME <u>Frederick T. Myers</u>				14. MOTHER'S MAIDEN NAME <u>Lydia A. Miner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-30-7824</u>			
17. INFORMANT <u>John A. Myers, Smithsburg, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>5 Yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-20</u> , 19 <u>54</u> , to <u>2-5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-4</u> , 19 <u>60</u> , and that death occurred at <u>3:35 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Charles F. Hess</u> M.D. <u>2-5-60</u>							
ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. <u>2-5-60</u>							
PHYSICIAN'S NAME (Type) <u>Charles F. Hess M.D.</u> <u>Smithsburg Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Smithsburg, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 8 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Curran S. Thoms</u>				24c. DATE <u>FEB 8 '60</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903



Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

2555

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02566

1. PLACE OF DEATH a. COUNTY Wash. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 909 Hamilton Blvd.	
3. NAME OF DECEASED (Type or print) First Mildred Middle Elinor Last MYERS		4. DATE OF DEATH Month 2 Day 26 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH Sept. 30, 1914		9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 26 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school teacher		10b. KIND OF BUSINESS OR INDUSTRY public school		11. BIRTHPLACE (State or foreign country) Cherry Run, W. Va.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Ira Stater		14. MOTHER'S MAIDEN NAME Berna Bartgis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-18-5087		INFORMANT Address Capt. Stanley V. Stater, Gainesville, F.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency 175.0 DUE TO Pleural metastasis with effusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Adeno carcinoma of ovary, bilateral (b) 8 months (c) 6 months		INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from January 27, 1960 to Feb. 26, 1960 that I last saw the deceased alive on Feb. 26, 1960 and that death occurred at 9:50 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Young E. Chun		M.D. 1500 Penna. Ave. Hagerstown, Md.		DATE SIGNED Feb. 26, 1960	
PHYSICIAN'S NAME (Type) Dr. Young E. Chun					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Feb. 28, 60		22c. NAME OF CEMETERY OR CREMATORY Stater Chapel	
22d. LOCATION (City, town, or-county) (State) Cherry Run, W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAR 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2

091

1

1

CERTIFICATE OF DEATH

225

Wash.

Wash.

Hagerstown

2 years

Hagerstown

909 Hamilton Blvd.

Western Maryland State Hospital

MYERS

Elmer

Milner

Sept. 30, 1914

Female white

Cherry Run, W. Va.

Public school

School teacher

Born Hagerstown

Her father

377-18-5087 Capt. Stanley V. Staser, Cincinnati, O.

10

Witnessed by

The undersigned

in the presence of

the following persons

who are

competent

to

swear

that

the

above

signed

and

120. 28, 30 West Chapel

Cherry Run, W. Va.

Scott R. Minton & Son, Hagerstown, Md.

2556

CERTIFICATE OF DEATH

Reg. Dist. No. 302

02567

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 Week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>LESTER</u> Last <u>MYERS</u>				4. DATE OF DEATH Feby 9 1960			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 20 1874</u>	
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Cearfoss Wash Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Myers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sprankle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Harry G Myers Hagerstown R # 4 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Cardio Vascular System</u> (c) <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-1-60</u> , 19 <u>60</u> to <u>2-9-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-7-60</u> , 19 <u>60</u> , and that death occurred at <u>54</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>2/9/60</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>Dr E W Dittus Jr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF NEW YORK

3250



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02569

2622

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Route 3		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Robert Last Nave		4. DATE OF DEATH Month 2 Day 1 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 2 Days 1	IF UNDER 24 HRS. Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yardman		10b. KIND OF BUSINESS OR INDUSTRY W. Md. R. R.	
11. BIRTHPLACE (State or foreign country) Williamsport, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Nave		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-4990	
17. INFORMANT Mrs. Anna Nave		Address Hagerstown, Md. Route 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chr. Myocarditis (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 hours 5 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE [Signature] M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. J. T. T. J.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/2/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2-4-60	22c. NAME OF CEMETERY OR CREMATORY River View Cemetery	22d. LOCATION (City, town, or county) (State) Williamsport Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR FEB 5 '60		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 78
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Blank]		2. SEX [Blank]		3. AGE [Blank]		4. DATE OF BIRTH [Blank]	
5. PLACE OF BIRTH [Blank]		6. OCCUPATION [Blank]		7. MARITAL STATUS [Blank]		8. COLOR [Blank]	
9. STREET ADDRESS [Blank]		10. CITY [Blank]		11. COUNTY [Blank]		12. STATE [Blank]	
13. DATE OF DEATH [Blank]		14. TIME OF DEATH [Blank]		15. PLACE OF DEATH [Blank]		16. CAUSE OF DEATH [Blank]	
17. MANNER OF DEATH [Blank]		18. SIGNATURE OF EXAMINER [Blank]		19. TITLE OF EXAMINER [Blank]		20. DATE OF EXAMINATION [Blank]	
21. SIGNATURE OF WITNESS [Blank]		22. TITLE OF WITNESS [Blank]		23. DATE OF WITNESSING [Blank]		24. SIGNATURE OF REGISTRAR [Blank]	
25. TITLE OF REGISTRAR [Blank]		26. DATE OF REGISTRATION [Blank]		27. SIGNATURE OF CLERK [Blank]		28. TITLE OF CLERK [Blank]	
29. SIGNATURE OF CLERK [Blank]		30. TITLE OF CLERK [Blank]		31. SIGNATURE OF CLERK [Blank]		32. TITLE OF CLERK [Blank]	
33. SIGNATURE OF CLERK [Blank]		34. TITLE OF CLERK [Blank]		35. SIGNATURE OF CLERK [Blank]		36. TITLE OF CLERK [Blank]	
37. SIGNATURE OF CLERK [Blank]		38. TITLE OF CLERK [Blank]		39. SIGNATURE OF CLERK [Blank]		40. TITLE OF CLERK [Blank]	
41. SIGNATURE OF CLERK [Blank]		42. TITLE OF CLERK [Blank]		43. SIGNATURE OF CLERK [Blank]		44. TITLE OF CLERK [Blank]	
45. SIGNATURE OF CLERK [Blank]		46. TITLE OF CLERK [Blank]		47. SIGNATURE OF CLERK [Blank]		48. TITLE OF CLERK [Blank]	
49. SIGNATURE OF CLERK [Blank]		50. TITLE OF CLERK [Blank]		51. SIGNATURE OF CLERK [Blank]		52. TITLE OF CLERK [Blank]	
53. SIGNATURE OF CLERK [Blank]		54. TITLE OF CLERK [Blank]		55. SIGNATURE OF CLERK [Blank]		56. TITLE OF CLERK [Blank]	
57. SIGNATURE OF CLERK [Blank]		58. TITLE OF CLERK [Blank]		59. SIGNATURE OF CLERK [Blank]		60. TITLE OF CLERK [Blank]	
61. SIGNATURE OF CLERK [Blank]		62. TITLE OF CLERK [Blank]		63. SIGNATURE OF CLERK [Blank]		64. TITLE OF CLERK [Blank]	
65. SIGNATURE OF CLERK [Blank]		66. TITLE OF CLERK [Blank]		67. SIGNATURE OF CLERK [Blank]		68. TITLE OF CLERK [Blank]	
69. SIGNATURE OF CLERK [Blank]		70. TITLE OF CLERK [Blank]		71. SIGNATURE OF CLERK [Blank]		72. TITLE OF CLERK [Blank]	
73. SIGNATURE OF CLERK [Blank]		74. TITLE OF CLERK [Blank]		75. SIGNATURE OF CLERK [Blank]		76. TITLE OF CLERK [Blank]	
77. SIGNATURE OF CLERK [Blank]		78. TITLE OF CLERK [Blank]		79. SIGNATURE OF CLERK [Blank]		80. TITLE OF CLERK [Blank]	
81. SIGNATURE OF CLERK [Blank]		82. TITLE OF CLERK [Blank]		83. SIGNATURE OF CLERK [Blank]		84. TITLE OF CLERK [Blank]	
85. SIGNATURE OF CLERK [Blank]		86. TITLE OF CLERK [Blank]		87. SIGNATURE OF CLERK [Blank]		88. TITLE OF CLERK [Blank]	
89. SIGNATURE OF CLERK [Blank]		90. TITLE OF CLERK [Blank]		91. SIGNATURE OF CLERK [Blank]		92. TITLE OF CLERK [Blank]	
93. SIGNATURE OF CLERK [Blank]		94. TITLE OF CLERK [Blank]		95. SIGNATURE OF CLERK [Blank]		96. TITLE OF CLERK [Blank]	
97. SIGNATURE OF CLERK [Blank]		98. TITLE OF CLERK [Blank]		99. SIGNATURE OF CLERK [Blank]		100. TITLE OF CLERK [Blank]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2558
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02570

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. HOSPITAL</u>				d. STREET ADDRESS <u>HAGERSTOWN MD. R. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>FRANK</u> Last <u>NEWCOMER</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 22 - 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>22</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BEAVER CREEK WASH. Co. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MARTIN L. NEWCOMER</u>				14. MOTHER'S MAIDEN NAME <u>BETTY MCSAULEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>219-20-0701</u>		17. INFORMANT <u>MRS. SALLIE NEWCOMER HAGERSTOWN MD. R. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO <u>(primary site not determined due to condition)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonitis, left lower lobe. The primary cause of this may have been G-I malignancy.</u> DUE TO (c) <u>Indefinite.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>February 5, 1960</u> to death <u>February 14, 1960</u> , that (I) (we) last saw the deceased alive on <u>February 14, 1960</u> , and that death occurred at <u>5:25 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert F. Keadle</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>February 15, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M. D.</u>				22d. ADDRESS <u>318 North Potomac Street Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 17, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK WASH. Co. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>FEB 18 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>C. Chas. L. Keadle</u>	

CERTIFICATE OF DEATH

9558

1

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Boonesboro #1		c. LENGTH OF STAY IN 1b 13 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Memorial Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cyrus Newcomer		4. DATE OF DEATH Month Day Year Feb. 2, 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1873
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Ringgold, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin F. Newcomer		14. MOTHER'S MAIDEN NAME Mary M. Garver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. William B. Newcomer, Smithsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vascular Disease (c) 5 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-1-59 , 19____, to 2-2-60 , that I last saw the deceased alive on 2-1-60 , 19____, and that death occurred at 5:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter J. Grove		DATE SIGNED 7/4/60	
PHYSICIAN'S NAME (Type) Walter J. Grove		M.D. Arthur L. Kraus	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/60	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg		22d. LOCATION (City, town, or county) (State) Smithsburg, Washington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Grove		24a. REC'D BY REGISTRAR DATE FEB 5 '60	
ADDRESS Walter J. Grove		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

SECRET

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2559

CERTIFICATE OF DEATH

02572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CHESTNUT GROVE - RURAL d. STREET ADDRESS KEEDYSVILLE MD. R. 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH FRANKLIN NICK		4. DATE OF DEATH Month Day Year FEBRUARY - 6 - 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL - 17 - 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 9 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) HARDERS FERRY W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN NICK		14. MOTHER'S MAIDEN NAME JENNIE BUSSARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT MRS. MAUDE NICK KEEDYSVILLE MD. R. 1.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonitis 480x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) Influenza DUE TO (c) 15 days		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertrophy of the prostate.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 24 , 19 60 , to 2/6/60 , 19 60 , that I last saw the deceased alive on 2/6/60 , 19 60 , and that death occurred at 12 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 2/8/60 ACTUAL SIGNATURE Walter H. Shealy M.D. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 9. 1960	
22c. NAME OF CEMETERY OR CREMATORY BOHRSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) BOHRSVILLE WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John N. East		24a. REC'D BY REGISTRAR DATE FEB 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

8229

1

DEATH

IN FORM

STATE OF NEW YORK

DEATH

AND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2560
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02573

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 1/2 hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Hoover Last Paulsgrove		4. DATE OF DEATH Month February Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1909
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Manager		10b. KIND OF BUSINESS OR INDUSTRY Radio	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Earl Paulsgrove		14. MOTHER'S MAIDEN NAME Norah Hoover	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war-or-dates of service) W. W. 11 214-09-6227	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant Lymphoma (Liver & lymph nodes) DUE TO (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10.157 , 19____, to _____, 19____, that I last saw the deceased alive on 2.18.60 , 19____, and that death occurred on 10.30 , 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE Scott F. Minnich & Son		DATE SIGNED 148 N. Potomac St.	
PHYSICIAN'S NAME (Type) S. Earl Young		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

CENTRAL AMERICAN DEATH

Washington

Washington

Washington

Washington

Washington

Washington

1805 Howard Road

Washington County Hospital

20

18

February

Washington

Washington

Washington

August 10, 1909

White

Washington

Radio

Station Manager

Norman Hoover

Radio

Washington

Washington

Washington

Washington

Washington

Washington

20

Washington

Washington

Washington

Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2553
CERTIFICATE OF DEATH

Reg. Dist. No.

02576

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mercersburg, Pa.	
3. NAME OF DECEASED (Type or print) First GRACE Middle S. Last PEIRSON		4. DATE OF DEATH Month Feb. Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Sodus Point, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sheffield		14. MOTHER'S MAIDEN NAME Kittie Rogers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Dr. L.H. Hitzrot, Mercersburg, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrhythmia prob ventr fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute pulmonary edema (c) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH seconds one hour years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/29 , 19 59 , to 2/19 , 19 60 , that I last saw the deceased alive on 2/19 , 19 60 , and that death occurred at 11:20 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 2/10/60			
ACTUAL SIGNATURE John C. Stouffer		M.D. John C. Stouffer	
PHYSICIAN'S NAME (Type) John C. Stouffer			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 2/23/60	
22c. NAME OF CEMETERY OR CREMATORY Henninger's F.H.		22d. LOCATION (City, town, or county) (State) Reading, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Seminger		ADDRESS Mercersburg, Pa.	
24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE Chas. S. Kiser	

2561

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LLOYD Middle LE ROY Last PENNER				4. DATE OF DEATH Month February Day 27 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1894	
9. AGE (In years lost birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		11. BIRTHPLACE (State or foreign country) Brunswick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Penner				14. MOTHER'S MAIDEN NAME ? Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 705-12-2139			
17. INFORMANT Mrs. Helen Penner				Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma, right 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 14 months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec. 12 , 19 58 , to Feb. 27 , 19 60 , that I last saw the deceased alive on Feb. 27 , 19 60 , and that death occurred at 9:05 P.M. , from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. 2/29/60 DATE SIGNED							
ACTUAL SIGNATURE William T. Layman				PHYSICIAN'S NAME (Type) Hagerstown Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR MAR 2 '60 DATE	
24b. REGISTRAR'S SIGNATURE Robert S. Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 946 Mulberry Ave.			d. STREET ADDRESS 946 Mulberry Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EUGENE Middle JOHN Last PHILLIPS			4. DATE OF DEATH Month February Day 9 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1886		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Eng. Draftsman		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Co.	11. BIRTHPLACE (State or foreign country) Budapest, Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Phillips			14. MOTHER'S MAIDEN NAME Cecilia ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-C668A	17. INFORMANT Mrs. Eleanor Ridenour		Address Hagerstown, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Hypertension Cerebro Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO 6 yrs (b) 6 yrs (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE [Signature]		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/11/60	
EXAMINER'S NAME (Type) DR F W T T T		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/12/1960	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR FEB 15 '60	24b. REGISTRAR'S SIGNATURE [Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
MEDICAL HISTORY [REDACTED]		PRESENT ILLNESS [REDACTED]		TREATMENT [REDACTED]	
PHYSICIAN'S SIGNATURE [REDACTED]		MEDICAL EXAMINER'S SIGNATURE [REDACTED]		COUNTY CLERK'S SIGNATURE [REDACTED]	
CITY CLERK'S SIGNATURE [REDACTED]		STATE CLERK'S SIGNATURE [REDACTED]		COUNTY CLERK'S SIGNATURE [REDACTED]	

This certificate is to be filled out by the Medical Examiner of the County in which the death occurred. It is to be filed in the office of the County Clerk, and a copy of it is to be sent to the State Department of Health. The Medical Examiner is to be a physician who is a member of the Maryland Medical Association. The County Clerk is to be a person who is a member of the County Board of Health. The State Clerk is to be a person who is a member of the State Board of Health. The County Clerk is to be a person who is a member of the County Board of Health. The State Clerk is to be a person who is a member of the State Board of Health.

2600
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO		c. LENGTH OF STAY IN 1b 2 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle REBECCA Last PLUMMER		4. DATE OF DEATH Month FEBRUARY Day 5 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/1867
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM DEWEESE		14. MOTHER'S MAIDEN NAME MARIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. EDWARD D. PLUMMER		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Jan 1955 , to 5 Feb 1960 , that I last saw the deceased alive on 29 Jan 1960 , and that death occurred at 7:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2301 Poloma St Hagerstown DATE SIGNED 6 Feb 60			
ACTUAL SIGNATURE F F Lusby		M.D. Hagerstown	
PHYSICIAN'S NAME (Type) F F Lusby			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/8/60	22c. NAME OF CEMETERY OR CREMATORY MANCHESTER CEM.	22d. LOCATION (City, town, or county) (State) MANCHESTER MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. T. Thormont		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR FEB 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2564

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02578

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 400 Reynolds Ave.			
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle FRANKLIN Last POFFENBERGER				4. DATE OF DEATH Month February Day 1 Year 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1869		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Doorman		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Poffenberger				14. MOTHER'S MAIDEN NAME Julia Burgesser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-3620		17. INFORMANT Charles C. Poffenberger Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture Femur (c) Arterio-sclerotic Heart Disease DUE TO causes lost.							INTERVAL BETWEEN ONSET AND DEATH 2 days 9 days 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on Porch of Home					
20c. TIME OF INJURY Month, Day, Year 1-23-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE DREW D. T. T. O. J.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) DREW D. T. T. O. J.				DATE SIGNED 2/2/60			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Super-Rouzer Funeral Home Hagerstown, Md.				24a. REC'D BY REGISTRAR FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2565

CERTIFICATE OF DEATH

Reg. Dist. No.

02579

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Blessing Last Rensburg				4. DATE OF DEATH Month Feb. Day 1 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27 1905	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 10 Dgys 5	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Jeffersonville Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Abram Blessing				14. MOTHER'S MAIDEN NAME Bertie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mr. Fred Rensburg Address 209 E. Main Street Sharpsburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X Thrombosis of the right internal carotid artery DUE TO Ligation of the carotid artery Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Ruptured aneurysm of the rt. middle cerebral artery DUE TO (c) Hypertensive arteriosclerotic cardio vascular disease							INTERVAL BETWEEN ONSET AND DEATH 1 week 11 days (21) 22 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from January 11 1960 , to Feb. 1 1960 that I last saw the deceased alive on February 1 1960 , and that death occurred at 12 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED Feb. 3, 60							
ACTUAL SIGNATURE Walter H. Shealy				M.D. Sharpsburg, Md.			
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Legg				ADDRESS Williamport, Maryland		24a. REC'D BY REGISTRAR FEB 5 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frame			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ESTIMATE OF DEATH

2522

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]

4. Age: [illegible]
5. Sex: [illegible]
6. Race: [illegible]

7. Occupation: [illegible]
8. Education: [illegible]
9. Marital status: [illegible]

10. Cause of death: [illegible]
11. Duration of illness: [illegible]
12. Date of admission: [illegible]

13. Date of death: [illegible]
14. Date of burial: [illegible]
15. Date of cremation: [illegible]

16. Date of interment: [illegible]
17. Date of exhumation: [illegible]
18. Date of reinterment: [illegible]

19. Date of removal: [illegible]
20. Date of return: [illegible]
21. Date of disposal: [illegible]

22. Date of final disposition: [illegible]
23. Date of final disposition: [illegible]
24. Date of final disposition: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2566 CERTIFICATE OF DEATH

Reg. Dist. No. 302

02580

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>5 Minutes</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>315 Linganore Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Rhodes</u> Last <u>Resh</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 12, 1898</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James B. Rhodes</u>	
14. MOTHER'S MAIDEN NAME <u>Claressa Hershberger</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service) <u> </u>	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>John B. Resh 208 Hager St. Hagerstown Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Hypertensive heart disease with</u> DUE TO (b) <u>chronic decompensation -</u> DUE TO (c) <u>General arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>10 yr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 10</u> , 19 <u>58</u> , to <u>Feb 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb - 2</u> , 19 <u>60</u> , and that death occurred at <u>2:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 West Washington St. Hagerstown, Md.</u> DATE SIGNED <u>2/3/60</u> ACTUAL SIGNATURE <u>Edward W. Ditto</u> , M.D. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D. Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-7-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church of God Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Clinton S. Hays</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MADE IN THE STATE OF NEW YORK

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02581

2567

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Franklin Benjamin Reynolds		4. DATE OF DEATH Month Day Year February 14, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1871
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Greensburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Reynolds		14. MOTHER'S MAIDEN NAME Lydia Stephey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Lydia Miller, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO Pulmonary edema and congestion (b) Tuberculous pneumonia (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 Metabolized Acetaminophen Acidosis		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 2 WEEKS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5, 1960, to Feb 14, 1960, that I last saw the deceased alive on Feb 14, 1960, and that death occurred at 11:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. R. Lardizabal		DATE SIGNED 2-15-60	
PHYSICIAN'S NAME (Type) E. R. Lardizabal		ADDRESS (Street, city or town, state) 12 S. Main Street Smithsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-17-60	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE FEB 17 '60	
24b. REGISTRAR'S SIGNATURE Orlino S. Kraus			

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MASTERSHIP IN THE ART OF HEALTH - MEDICAL 18

3333 - CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro				c. LENGTH OF STAY IN 1b 28 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last THEODORE CAMPBELL RUBIE				4. DATE OF DEATH Month Day Year February 17 19 60			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 30, 1890		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY construction Company		11. BIRTHPLACE (State or foreign country) Fincaastle, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Ruble				14. MOTHER'S MAIDEN NAME Lucy J. Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-05-5345		INFORMANT Mrs. Catherine C. Ruble		Address Boonsboro Rt. 2, Md.	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Arteriosclerosis of the Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Cerebral Thrombosis (c) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 20 minutes 3 hrs. 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Gangrenous Appendicitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Feb 21 , 19 59 , to Feb 17 , 19 60 , that I last saw the deceased alive on Feb 12 , 19 60 , and that death occurred at 9 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip J. Hirshman		ADDRESS (Street, city or town, State) 1594 Woodington St Hagerstown, Md 21740					
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		DATE SIGNED 2-18-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/1960	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Super-Rouzer Funeral Home		ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE Cuthbert S. House	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Page 111

Figure 1

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2568
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 20 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVA First MAE Middle SANBOWER Last		4. DATE OF DEATH FEBRUARY Month 19 Day 19 Year 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/1891
9. AGE (In years lost birthday) 68		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SHAW		14. MOTHER'S MAIDEN NAME AMANTHA PERRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT MRS AMANTHA CONWAY HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Anteriorly Occlusive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anteriorly Occlusive (c) Anteriorly Occlusive			INTERVAL BETWEEN ONSET AND DEATH 4 days yes yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-16 , 19 60 , to 2-19 , 19 60 , that I last saw the deceased alive on 2-19 , 19 60 and that death occurred at 1 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE D. J. Boyer		ADDRESS (Street, city or town, state) 135 North Potomac Street DATE SIGNED 2-20-60	
PHYSICIAN'S NAME (Type) Dr. D. J. Boyer		Hagerstown, Maryland	
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	22b. DATE THEREOF 2/22/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) CLEARSPRING MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR FEB 23 '60 24b. REGISTRAR'S SIGNATURE Charles E. Pineda	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

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CERTIFICATE OF DEATH

1938

State of New York

County of ...

City of ...

On the ... day of ...

at the age of ...

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... died ...

at ...

... after ...

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2625

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock	
c. LENGTH OF STAY IN 1b 70 Yrs		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last Sciese		4. DATE OF DEATH Month 2 Day 13 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4.10.1880
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months 79 Days 13 Hours 1960 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Morgan County W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Pryor		14. MOTHER'S MAIDEN NAME Mary Terry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. George W Sciese Rural Hancock Md.	
17. INFORMANT George W Sciese Rural Hancock Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Arteriosclerotic Heart Disease 30 years		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sensitivity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2.12.60 to 2.13.60 , that I last saw the deceased alive on 2.12.60 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE SAM Nichols M.D.		Beckley, W.Va. 2.15.60	
PHYSICIAN'S NAME (Type) SAM. Nichols			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2.16.60	22c. NAME OF CEMETERY OR CREMATOR Mt Olivet Presbyterian	22d. LOCATION (City, town, or county) (State) Rural Hancock Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Hancock		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>10/15/1917</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Occupation: <u>Engineer</u></p>		<p>8. Usual place of abode: <u>123 Main St. Boston</u></p>	
<p>9. Name of physician: <u>Dr. J. A. Smith</u></p>		<p>10. Name of undertaker: <u>John Doe</u></p>	
<p>11. Name of informant: <u>John Brown</u></p>		<p>12. Signature of informant: <u>[Signature]</u></p>	
<p>13. Name of registrar: <u>John Doe</u></p>		<p>14. Signature of registrar: <u>[Signature]</u></p>	

2569

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDGAR Last SEIBERT				4. DATE OF DEATH Month February Day 10 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 29, 1880	
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 9 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Conrad Seibert				14. MOTHER'S MAIDEN NAME Barbara Freise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-1730A		17. INFORMANT Mrs. Anna J. Seibert Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO 5 years (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 1-15-60 , to 2-10-60 , that I last saw the deceased alive on 2-9-60 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.			
21. ACTUAL SIGNATURE H. E. W. Dittus				21. ADDRESS (Street, city or town, state) Hagerstown, Maryland DATE SIGNED 7/1/60			
21. PHYSICIAN'S NAME (Type) D. E. W. Dittus				22. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/12/1960		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Inter-Rouzer Funeral Home H. Franklin Rouzer				24a. REC'D BY REGISTRAR FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

302

Washington

Washington

Washington

Washington

8 days

Washington

Washington General Hospital

22 Broadway

CHARLES

MALE

DECEASED

WEDNESDAY

Wife

Male

February 22, 1920

Other

Washington, D.C.

George Johnson

George Johnson

1920-02-22 New Anna L. Johnson, Washington, D.C.

George Johnson

George Johnson

George Johnson

George Johnson

George Johnson

George Johnson

CERTIFICATE OF DEATH

Reg. Dist. No. 3030

2570

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash county Hospital</u>				d. STREET ADDRESS <u>Hampton Road West</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIONEL EDWARD SELLMAN Sr</u>				4. DATE OF DEATH Month Day Year <u>Feb 23 1960 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-4-1903</u>	
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Vogel Ritt</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Clarence Edward Sellman</u>				14. MOTHER'S MAIDEN NAME <u>Sue Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>				16. SOCIAL SECURITY NO. <u>292-03-2777</u>			
INFORMANT Address <u>Mrs Blanche C. Sellman Williamsport Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> <u>180X</u> DUE TO <u>PAPILLARY CARCINOMA OF URETER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 Wks</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease and Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>death</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2-22-60</u> , 19 <u> </u> , and that death occurred at <u>8:05A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Harrison</u>				ADDRESS (Street, city or town, state) <u>318 N. Potomac St.</u>		DATE SIGNED <u>2-24-60</u>	
PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.</u>				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

CONFIDENTIAL

APR 21 1964

227

CENTRAL AVE OF DEATH

WILLIAM H. BENTLEY JR. - DEATH - BAPTIST

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
2571
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02587

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>940 E. Main St.,</u>				d. STREET ADDRESS <u>1 940 E. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>V</u> Last <u>Shank</u>				4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>19 60</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 13, 1879</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Big Pool, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Shives</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>J. Harry Shank</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Arterio Sclerotic heart disea</u> DUE TO (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Hypertension</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>2 yrs</u> <u>years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11a</u> <u>1960</u> to <u>14 Feb</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>12 Feb</u> <u>1960</u> , and that death occurred at <u>12:15 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edwin D. Hoachlen</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edwin D. Hoachlen</u>				22d. ADDRESS <u>Hagerstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2-17-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u> ADDRESS <u>Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraiss</u>	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

1911

CHIEF, BUREAU OF VITAL RECORDS

2572

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown,		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Dewey SHARPLESS		4. DATE OF DEATH 2 Month 7 Day 1960 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1900
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. Sharpless		14. MOTHER'S MAIDEN NAME Sarah Fulmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Stanley Sharpless Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary tract infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 25, 1960 , to February 7, 1960 , that I last saw the deceased alive on February 7, 1960 , and that death occurred at 1:55 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Young E. Chun		ADDRESS (Street, city or town, state) 1500 Penna Ave., Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Young E. Chun, M. D.		DATE SIGNED Feb. 7, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Reighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR FEB 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krawa	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Washington

Magistrate

2 weeks

Assistant

Western Maryland State Hospital

Male White 1800 18 1900 50

Coal Miner Bolt Coal Mines Maryland U.S.A.

William B. Sharpless

Sarah Palmer

Stanley Sharpless Deep Fork, Md.

4 years

Young, M. D. 1900 form, Dr. H. H. Henshaw, Md.

2/1900 1st. John C. Henshaw, Henshaw County, Maryland.

England, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

262E

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Chambersburg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Rural</u>		c. LENGTH OF STAY IN 1b <u>75X-3</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gateway Convalescent Home</u>				d. STREET ADDRESS <u>434 Guilford Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>S.</u> Last <u>Sheffler</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 11, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Sheffler</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Ira S. Sheffler Jr</u> Address <u>115 Haywood Ave Bound Brook, N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sclerotic Heart Dis 2y Sudden</u> <u>420.0</u> DUE TO <u>Acute Cardiac Failure</u> 6 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Cardiac Failure</u> (c) <u>6 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>David R. Brewer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Attending Physician</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3/1/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg Franklin Co Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Fun. Home</u>				305 N. Potomac St Hagerstown. Md.		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Rouse</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2573 **CERTIFICATE OF DEATH**

02590

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Donald Last Sherman				4. DATE OF DEATH Month 2 Day 28 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 8, 1906	
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) musician				10b. KIND OF BUSINESS OR INDUSTRY club musician		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME A. H. Sherman				14. MOTHER'S MAIDEN NAME Rose Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT A. H. Sherman Address 909 Mulberry Ave., City			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrothorax right ascites abdominous 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) unknown							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from February 27, 1960 to February 28, 1960 that (I) (we) saw the deceased alive on Feb. 27, 1960 , and that death occurred at 2:15 from the causes and on the date stated above.							
22a. SIGNATURE <i>W. T. Layman</i>				22b. DATE 2/29/60		22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.	
22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-1-60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				25a. REC'D BY REGISTRAR MAR 2 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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2574
CERTIFICATE OF DEATH

Reg. Dist. No.

02591

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS W. Main Street	
3. NAME OF DECEASED (Type or print) First Felix Middle Oscar Last Shorb		4. DATE OF DEATH Month February Day 11 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton		10b. KIND OF BUSINESS OR INDUSTRY Catholic Church	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Shorb		14. MOTHER'S MAIDEN NAME Martha Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-30-3413	
17. INFORMANT Loretta T. Shorb,		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arterio sclerosis (c) cerebral arterio sclerosis			INTERVAL BETWEEN ONSET AND DEATH 10 minutes 10 yrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) total urinary retention			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 5 , 19 60 , to Feb 11 , 19 60 , that I last saw the deceased alive on Feb 10 , 19 60 , and that death occurred at 5:17 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Joseph C. Crisp		M.D.	
PHYSICIAN'S NAME (Type) Joseph C. Crisp		115 King St. Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-15-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

2522

Frederick

Maryland

Washington

Thurmont

11 days

Harrodsburg

Washington County Hospital

W. Main Street

x

February 11

Shorb

Causes

Felix

60

Jan. 16, 1886

x

male white

Sexton

Catholic Church Maryland

U.S.A.

Martin Baker

John Shorb

Thurmont, Md.

Loretta T. Shorb,

no

Harrodsburg, Kentucky

King St.

Joseph C. Oriskany

Thurmont, Maryland

St. Ann's Cemetery

2-15-60

Funeral

Thurmont, Maryland

Reverend J. Oriskany

CERTIFICATE OF DEATH

Reg. Dist. No.

02592

2575

1. PLACE OF DEATH a. COUNTY <i>Wash.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Pa.</i> b. COUNTY <i>Franklin</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Co. Hospital</i>		e. STREET ADDRESS <i>162 E. Madison St</i>	
3. NAME OF DECEASED (Type or print) <i>IVA</i> First <i>A.</i> Middle <i>SHUMAN</i> Last		4. DATE OF DEATH <i>Feb. 19, 1960</i> Month <i>19</i> Day Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/13/1888</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>State Line, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Cyrus Graham</i>		14. MOTHER'S MAIDEN NAME <i>Annie Ford</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>180-10-8658D</i>	
17. INFORMANT <i>Wm O. Shuman - Greencastle</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO (b) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days -</i> <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/5, 1958</i> , to <i>2/19, 1960</i> that I last saw the deceased alive on <i>2/19, 1960</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>John H. Hornbaker</i> M.D.		<i>154 West Washington Street 2:19:60</i>	
PHYSICIAN'S NAME (Type) <i>John H. Hornbaker, M.D.</i>		<i>Hagerstown, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2/22/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Greencastle Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A.E. Minnich - Greencastle</i>		ADDRESS <i>Greencastle Pa.</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 25 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knaus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO PRESS

2627

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport		c. LENGTH OF STAY IN 1b 4 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Williamsport		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 2			d. STREET ADDRESS 1 R.F.D. # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FREDERICK Middle LYOYD Last SLICK, SR.			4. DATE OF DEATH Month February Day 13 Year 1960		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1901		9. AGE (In years lost birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY super Market	11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William H. Slick			14. MOTHER'S MAIDEN NAME Emma Stouffer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-18-9221	17. INFORMANT Mrs. Fred Slick Address Williamsport, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion (Myocardial Infarction) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from Feb 8 , 1960, to Feb 13 , 1960, that I last saw the deceased alive on Feb 13 , 1960, and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2301 Federal St. Hagerstown, Md. DATE SIGNED 15 Feb 60					
ACTUAL SIGNATURE F. F. Lusby		PHYSICIAN'S NAME (Type) F. F. Lusby			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/16/1960	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 17 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

802

County of ... State of ...

Deceased ...

Age ...

Sex ...

Birth ...

Death ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Witness ...

Witness ...

Witness ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Doctor and Coroner's Report ...

Handwritten notes and signatures at the bottom left.

Handwritten notes and signatures at the bottom right.

CERTIFICATE OF DEATH

Reg. Dist. No.

02594

2576

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 10 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Columbus Middle James Last Smith		4. DATE OF DEATH Month Feb. Day 27 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 0 Days 10	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Made Ice		10b. KIND OF BUSINESS OR INDUSTRY Ice	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME David Smith		14. MOTHER'S MAIDEN NAME Minnie Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 18 7413	
17. INFORMANT Mrs. Howard M. Swain		Address Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Fracture of ribs. DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 4 Days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital heart failure			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car accident - M.E. notified	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June - , 19 59 , to 2-27- , 19 60 , that I last saw the deceased alive on 2-27- , 19 60 , and that death occurred at 6 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hewitt		ADDRESS (Street, city or town, state) Barnes MD -	
DATE SIGNED 2-24-1960			
PHYSICIAN'S NAME (Type) JOSEPH SECONDAR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 1-60	22c. NAME OF CEMETERY OR CREMATORY Manor Cemetery	22d. LOCATION (City, town, or county) (State) Tilghmanton Md.
23. FUNERAL DIRECTOR'S SIGNATURE Albert Lloyd Williamsport, Md.		24a. REC'D BY REGISTRAR DATE MAR 2 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

5232

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02595

2577

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 4 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARLOCK NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRA RAGAN SMITH		4. DATE OF DEATH FEBRUARY 8 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/1881
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY AIR CRAFT CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HIRAM SMITH		14. MOTHER'S MAIDEN NAME AMANDA GRIMM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 046-09-2815	
17. INFORMANT MRS. LUCILE SMITH		18. ADDRESS HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/20 , 19 57 to Feb. 8 , 19 60 ; that I last saw the deceased alive on Jan 18 24 60 , and that death occurred at 10 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip J. Hirshman		ADDRESS (Street, city or town, state) 159 W. Washington St. Hagerstown DATE SIGNED 2/9/60	
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/11/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR Hagerstown Md DATE FEB 12 '60	
		24b. REGISTRAR'S SIGNATURE O. H. S. Hume	

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CERTIFICATE OF DEATH

257

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
SIGNATURE
OFFICIAL

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02596

2578

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Pennsylvania</u> COUNTY <u>Crawford County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Odessa</u> Middle <u>Mae</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raleigh Harr</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Griffith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMA</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>CANCER OF BREAST WITH METASTASES</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 YEARS</u> <u>4-5 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PLEURAL EFFUSION WITH COLLAPSE OF RIGHT LUNG</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 DEC. L</u> , 19 <u>59</u> , to <u>23 FEB.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>23 FEB.</u> , 19 <u>60</u> , and that death occurred at <u>1:15 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard T. Binford</u>		ADDRESS (Street, city or town, state) <u>1135 POTOMAC AVE</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M. D.</u>		DATE SIGNED <u>23 FEB. 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Meadeville, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>		ADDRESS <u>Williamsport, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hump</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

02597

2628

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>40 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown #5</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>O.</u> Last <u>Snurr</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1, 1885</u>	
9. AGE (In years lost birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Middletown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>							
13. FATHER'S NAME <u>Simon Snurr</u>				14. MOTHER'S MAIDEN NAME <u>Ella Junckle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>Mrs. Carrie S. Snurr Hagerstown #5, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10+ yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan. 3, 1957</u> , to <u>Feb. 10, 1960</u> , that I last saw the deceased alive on <u>Nov. 17, 1959</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph J. Miller</u>				ADDRESS (Street, city or town, state) <u>204 W. Main St. Waynesboro, Pa.</u>			
DATE SIGNED <u>2/11/60</u>							
PHYSICIAN'S NAME (Type) <u>JOSEPH J. MILLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kate J. Grose</u>				ADDRESS <u>Waynesboro, Penna.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF BIRTH [Faint text, possibly "Jan 1, 1930"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]		OCCUPATION [Faint text, possibly "Teacher"]	
DATE OF DEATH [Faint text, possibly "Feb 1, 1975"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		MEDICAL ATTENDANT [Faint text, possibly "Dr. J. Smith"]		SIGNATURE OF MEDICAL ATTENDANT [Faint signature]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
ADDRESS OF DECEASED [Faint text, possibly "123 Main St, Baltimore, Md"]		ADDRESS OF NEXT OF KIN [Faint text, possibly "456 Oak St, Baltimore, Md"]		ADDRESS OF REGISTRAR [Faint text, possibly "789 Pine St, Baltimore, Md"]	
CITY OF DECEASED [Faint text, possibly "Baltimore"]		CITY OF NEXT OF KIN [Faint text, possibly "Baltimore"]		CITY OF REGISTRAR [Faint text, possibly "Baltimore"]	
STATE OF DECEASED [Faint text, possibly "Maryland"]		STATE OF NEXT OF KIN [Faint text, possibly "Maryland"]		STATE OF REGISTRAR [Faint text, possibly "Maryland"]	
COUNTY OF DECEASED [Faint text, possibly "Baltimore"]		COUNTY OF NEXT OF KIN [Faint text, possibly "Baltimore"]		COUNTY OF REGISTRAR [Faint text, possibly "Baltimore"]	
ZIP CODE OF DECEASED [Faint text, possibly "21201"]		ZIP CODE OF NEXT OF KIN [Faint text, possibly "21201"]		ZIP CODE OF REGISTRAR [Faint text, possibly "21201"]	

BALTIMORE, MD

2629

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Smithsburg #2				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Smithsburg #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Elmer Last Spencer				4. DATE OF DEATH Month Feb. Day 29, Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 24, 1915	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Smithsburg #2	
13. FATHER'S NAME Frank E. Spencer				14. MOTHER'S MAIDEN NAME Ida L. Schildt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frank E. Spencer, Smithsburg Md., #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arterio-sclerosis DUE TO (c) Generalized Arterio-sclerosis				INTERVAL BETWEEN ONSET AND DEATH 30 min 5 years 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic heart-disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July - 1940 , to 2 - 29, 1960 , that I last saw the deceased alive on 2 - 7 - 1960 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter H. Wishard				ADDRESS (Street, city or town, state) DATE SIGNED 152 W. Main - Waynesboro Pa. 3-1-60			
PHYSICIAN'S NAME (Type) Walter H. Wishard							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/60		22c. NAME OF CEMETERY OR CREMATORY Harbaugh's		22d. LOCATION (City, town, or county) (State) Smithsburg #2, Franklin Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Groves, Waynesboro, Pa.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keedysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keedysville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>R. 7. D. # 1</u>	
3. NAME OF DECEASED (Type or print) <u>George Downey Sperow</u>		4. DATE OF DEATH <u>Feb. 10, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 19, 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR <u>13</u> Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Berkeley Co. W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Cromwell R. Sperow</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Rine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(11 yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs Robert A. Siler</u>		Address <u>R. # 1, Keedysville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>3 months.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-2-</u> , 19 <u>60</u> , to <u>2-9-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-9-</u> , 19 <u>60</u> , and that death occurred at <u>12:01 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Secondary</u>		ADDRESS (Street, city or town, state) <u>Boonsboro MD</u> DATE SIGNED <u>2-11-60</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/13/60</u>	<u>Spring Mills Cem.</u>	<u>Adgesville W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold K. Brown</u>		24a. REC'D BY REGISTRAR <u>W. H. Brown</u> DATE <u>2-12-60</u>	
ADDRESS <u>Martinsburg</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02600

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 48 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Howard Spiker		4. DATE OF DEATH Month Day Year February 15 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1898
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) Harrisonburg Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward S. Spiker		14. MOTHER'S MAIDEN NAME Emma Crabill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 219-12-1918	
17. INFORMANT Address Mrs. Marguerite Heim Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 13 , 19 60 to Feb. 15 , 19 60 ; that I last saw the deceased alive on Feb. 15 , 19 60 , and that death occurred at 8:50a M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St. Hagerstown Md. DATE SIGNED 2/16/60			
ACTUAL SIGNATURE Lloyd A. Hoffman M.D.			
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-18-60	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR FEB 19 60 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

STATEMENT OF DEATH

Washington

Maryland

Washington

Washington

18 years

Washington

115 Jefferson St.

Washington County Hospital

Physician

Robert

William

Nov. 22, 1933

White

Male

Interment

Interment

Interment

Emma O'Sullivan

Edward A. O'Sullivan

210-15-1015 Mr. Margarette Helen O'Sullivan

115 Jefferson St.

Washington D.C.

Washington D.C.

Washington

Washington

2-15-33

115 Jefferson St.

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 550 Highland Way		d. STREET ADDRESS 550 Highland Way	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle C. Last STARTZMAN		4. DATE OF DEATH Month February Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1880
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy Salesman		10b. KIND OF BUSINESS OR INDUSTRY candy Company	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel R. Startzman		14. MOTHER'S MAIDEN NAME Lily Startzman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
INFORMANT Mrs. W. E. Martin		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Anteroselective Heart Disease DUE TO (b) Acute Cholecystitis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 14 days 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:00 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 , 19____, to 2/19/60 , 19____, that I last saw the deceased alive on 2/9/60 , 19____, and that death occurred at 8:00 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Searl Young		ADDRESS (Street, city or town, state) 145 M. Baltimore	
PHYSICIAN'S NAME (Type) SEARL YOUNG M.D.		DATE SIGNED 2/11/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/1960	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		24a. REC'D BY REGISTRAR FEB 15 '60	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

242

15704 • • • 272

202

2581

CERTIFICATE OF DEATH

02602

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 50 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 820 MULBERRY AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELMER ELLSWORTH STITZEL First Middle Last				4. DATE OF DEATH FEBRUARY 21 19 60 Month Day Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/1882	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED YARD MASTER				10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MARTIN L. STITZEL				14. MOTHER'S MAIDEN NAME ROSE ANNE FARROW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-10-5284		INFORMANT MRS. THELMA I SIMON Address WASHINGTON D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma. 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.							INTERVAL BETWEEN ONSET AND DEATH 1 year.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 9, 1959 to Feb. 21, 1960 , that I last saw the deceased alive on Feb. 21, 1960 , and that death occurred at 12:10 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE R.A. Bell				ADDRESS (Street, city or town, state) 119 N. Potomac St. Hagerstown, Maryland.			
PHYSICIAN'S NAME (Type) R.A. Bell, M.D.				DATE SIGNED 2-22-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/24/60		22c. NAME OF CEMETERY OR CREMATORY BEST HAVEN CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W.J. Hornum				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR FEB 25 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2521

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Registration		Place of Registration	

2582

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	c. LENGTH OF STAY IN 1b 25 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WILLIAMSPORT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS CHERRY TREE LANE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NORMAN Middle ELDRIDGE Last SWARTZ		4. DATE OF DEATH Month FEBRUARY Day 12 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/1925
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months 34 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WHOLESALE FOOD DISTRIBUTOR		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NORMAN E. SWARTZ SR.	
14. MOTHER'S MAIDEN NAME MYRTLE LUTTRELL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. 220-16-2035		INFORMANT MRS. DORIS SWARTZ	
17. ADDRESS WILLIAMSPORT RT. #2 MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic glomerulonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery sclerosis	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 11:30	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1135 POTOMAC AVENUE	
20f. (City or town) (County) (State) HAGERSTOWN, MARYLAND.		21. I certify that I attended the deceased from 8 Feb - 1960 , to 17 Feb - 1960 , that I last saw the deceased alive on 11 Feb - 1960 , and that death occurred at 4 A M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Richard T. Binford		DATE SIGNED 13 FEB. 60	
PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		ADDRESS (Street, city or town, state) HAGERSTOWN, MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/14/60	22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3583

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

STATE OF MARYLAND

Blank form with faint horizontal lines and vertical columns for data entry.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02604

2583

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Line</u> 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>State Line, Pa.</u>	
3. NAME OF DECEASED (Type or print) <u>Le Roy</u> First <u>S.</u> Middle <u>Swisher</u> Last		4. DATE OF DEATH <u>Feb.</u> Month <u>13,</u> Day <u>1960</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/1906</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M.P. Moller Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foreman</u>	
11. BIRTHPLACE (State or foreign country) <u>Shady Grove, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Swisher</u>		14. MOTHER'S MAIDEN NAME <u>Florence Gruber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-9108</u>	
17. INFORMANT <u>Mrs. Darocha Swisher</u>		Address <u>State Line Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>SECOND & THIRD DEGREE BURNS OF ENTIRE BODY SURFACE</u> 6 hours (c) <u>cause lost.</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Evidently smoking on couch which caught fire</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:30AM</u> a. m. <u>Feb. 13, 1960</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> HOME 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MIDDLEBURG-FRANKLIN Pa.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. W. Ditto, Jr.</u>		DATE SIGNED <u>2/13/60</u>	
EXAMINER'S NAME (Type) <u>E. W. Ditto, Jr. M. D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>2/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u>		ADDRESS <u>Greencastle, Pa.</u>	
24a. REC'D BY REGISTRAR <u>FEB 17 1960</u>		24b. REGISTRAR'S SIGNATURE	

2631

CERTIFICATE OF DEATH

Reg. Dist. No.

02605

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Clearspring		c. LENGTH OF STAY IN lb 5 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mercersburg, Pa. 75x-3		d. STREET ADDRESS R.D.#2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle L. Last SWORD		4. DATE OF DEATH Month Feb. Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/1871
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min.	IF UNDER 24 HRS. Months 88 Days 88 Hours 88 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Mercersburg, Pa., R.D.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel Levy	
14. MOTHER'S MAIDEN NAME Margaret Shaffer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. JOHN SECRIST, Clearspring, Md.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 443X DUE TO HYPERTENSIVE ARTERIO SCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) 7 MONTHS		INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-5- , 19 55 , to 1-2- , 19 60 , that I last saw the deceased alive on 1-2- , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE William C. Dovey M.D.		ADDRESS (Street, city or town, state) Rt. 1 Mercersburg, Pa.	
PHYSICIAN'S NAME (Type) William C. Dovey, M.D.		DATE SIGNED 2-10-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/60	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cem..		22d. LOCATION (City, town, or county) (State) Mercersburg, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. M. Springer		ADDRESS Mercersburg, Pa.	
24a. REC'D BY REGISTRAR FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

283

DATE OF DEATH: 1900

PLACE OF DEATH: 1900

1900

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

02606

2632

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DORSEY First MILTON Middle TALL Last				4. DATE OF DEATH Month February Day 8 Year 1960			
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 21, 1878	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) near Williamsport, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.			
INFORMANT Gateway Convalescent Home Address Hag., Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) General Arterio Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Feb 5, 1960 to Feb 8, 1960 , that I last saw the deceased alive on Feb 8, 1960 , and that death occurred at 11:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED Feb 10, 1960							
ACTUAL SIGNATURE Arthur S. Kraus M.D.							
PHYSICIAN'S NAME (Type) Arthur S. Kraus							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR FEB 15 '60 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

263

Washington

John Washington

6 months

His death

Agency Government House

127 North Ave

WHITE

NEW YORK

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NEW YORK

White

NY

October 22, 1879

Patron

New York, N.Y. U.S.A.

unknown

unknown

no

Agency Government House

1879

NEW YORK, N.Y.

NEW YORK, N.Y.

NEW YORK, N.Y.

NEW YORK, N.Y.

NEW YORK, N.Y.

NEW YORK, N.Y.

NEW YORK, N.Y.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02607

2584

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>03</u> <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY J. E. THOMAS</u>		4. DATE OF DEATH Month Day Year <u>February 25 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 3 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Ada Mumma</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Franklin M. Thomas</u>		Address <u>No Jonathan St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abscess Of Lung, Right Lower Lobe.</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Broncho Pneumonia, Bilateral</u> DUE TO (c) <u>2 weeks.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>At View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Wash Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2585

CERTIFICATE OF DEATH

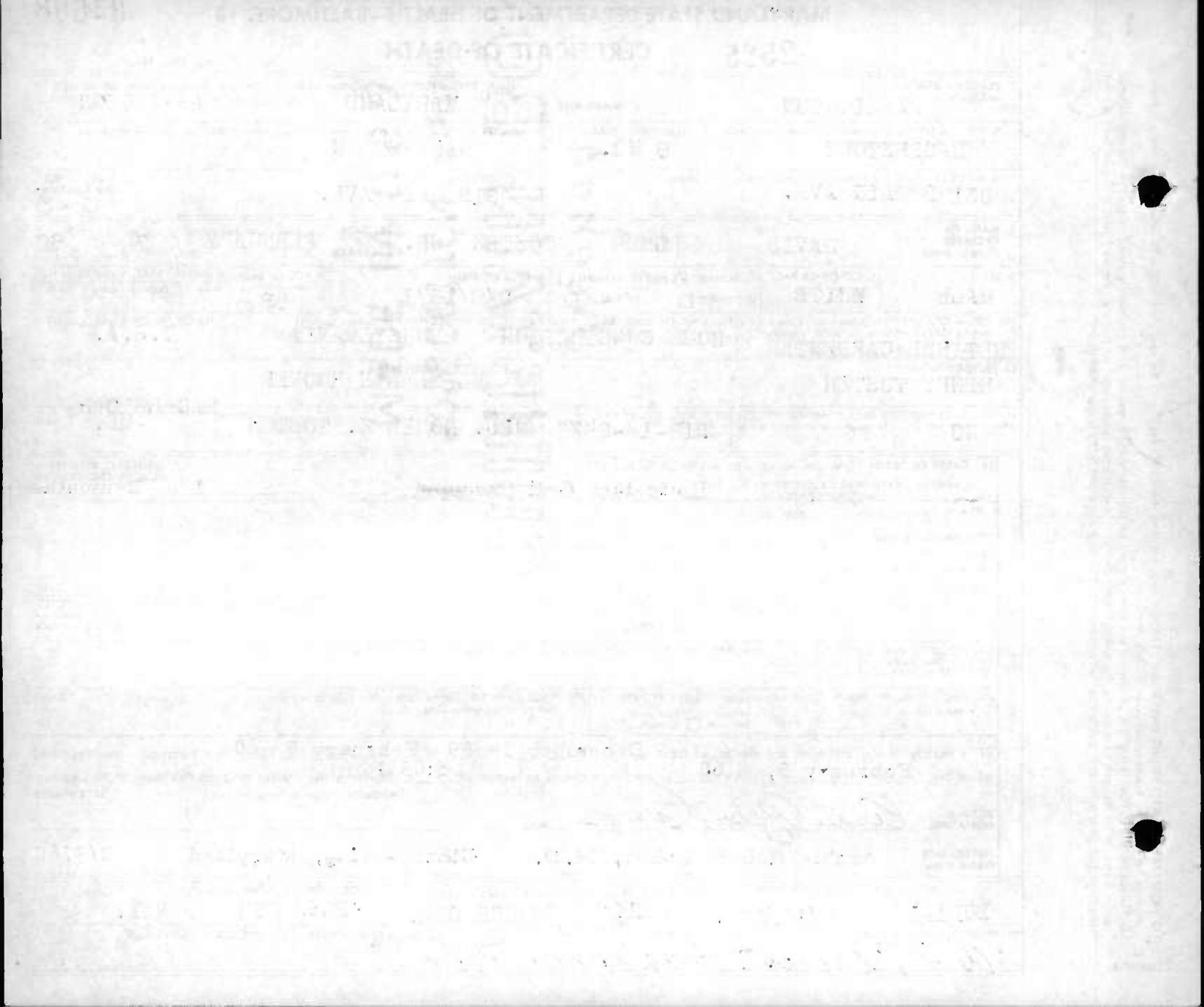
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 8 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 931 B MAIN AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID First ELMER Middle TOSTEN Last SR.		4. DATE OF DEATH FEBRUARY Month 7 Day 19 Year 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/1871
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY HOME CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY TOSTEN		14. MOTHER'S MAIDEN NAME ELIZABETH HOOVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-14-6636	
17. INFORMANT MRS. NONIE K. TOSTEN		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum Cell Sarcoma 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 19 59 to February 7, 1960 , that I last saw the deceased alive on February 5, 1960 , and that death occurred at 5:05 PM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D. Clear Spring, Maryland 2/9/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/10/60	22c. NAME OF CEMETERY OR CREMATORY DUNKARD CHURCH CEM.	22d. LOCATION (City, town, or county) (State) WELSH RUN PENNA.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment</i> ADDRESS <i>Hagerstown, Md.</i>		24a. REC'D BY REGISTRAR FEB 12 '60 DATE	24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2586
CERTIFICATE OF DEATH

02609

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Alice Last Unger		4. DATE OF DEATH Month February Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 1 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Morgan County, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Wise		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-7131	
17. INFORMANT Alvin Unger, Hagerstown, Md.		17. ADDRESS 715 Medway Drive,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease with H. sided 420.0 DUE TO Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Acute Pulmonary Bronchitis with asthma DUE TO (c) 1 week		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 Feb 19 60 , to 26 Feb 19 60 , that (I) (<input checked="" type="checkbox"/>) last saw the deceased alive and 26 Feb 19 60 , and that death occurred at 8:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Frank F. Lusby		22b. DATE SIGNED 1 Mar 60	
22c. PHYSICIAN'S NAME (Type) Frank F. Lusby, MD		22d. ADDRESS 230 Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/29/60	
23c. NAME OF CEMETERY OR CREMATORY Greenway Cem.		23d. LOCATION (City, town, or county) (State) Berkeley Springs, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE PARKS FUNERAL HOME, Berkeley Spgs. W. Va.		25a. REC'D BY REGISTRAR MAR 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kram			

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2587

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 4 Weeks d. NAME OF HOSPITAL (If not in hospital, give street address) Western Md. State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Amascus d. STREET ADDRESS 8650 Main e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith First Estelle Middle Wachter Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH 2 Month 15 Day 1960 Year 8. DATE OF BIRTH Dec. 5 1882 9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ### 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Hawkins		14. MOTHER'S MAIDEN NAME Lda Lavinia Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None INFORMANT Mrs. Cordelia Nichols Address Same Ag 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Cerebrovascular accident DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hours 8 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19, 1960 to Feb. 15, 1960 that I last saw the deceased alive on Feb. 15, 1960 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Young E. Churn		ADDRESS (Street, city or town, state) 1500 Penna. Ave. Hagerstown, Md. DATE SIGNED Feb. 16, 1960	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 18 1960	22c. NAME OF CEMETERY OR CREMATORY Etchison Meth.	22d. LOCATION (City, town, or county) (State) Etchison Md.
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md		24a. REC'D BY REGISTRAR FEB 18 1960 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Knaus

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

RESIDENCE

AGE

SEX

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Undertaker

Signature of Health Officer

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

CERTIFICATE OF DEATH

Reg. Dist. No.

02611

2588

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 11 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 145 East Franklin St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROSANNA GUYER WEBB				4. DATE OF DEATH Month Day Year Feby 9 1960 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20 1902		9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pa Latrobe Westmorland Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William M. Guyer				14. MOTHER'S MAIDEN NAME Euphemia Baumgardner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Francis L. Webb 145 E. Franklin St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 8 , 19 60 , to Feb 9 , 19 60 , that I last saw the deceased alive on Feb 8 , 19 60 , and that death occurred at 6:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Paul Harrison M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE FEB 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CHICAGO, ILL. (2)

APR 20 1904

CERTIFICATE OF DEATH

2528

Blank certificate form with horizontal lines for text entry.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2589 CERTIFICATE OF DEATH

02612

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>TWO DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>C. CLEVELAND - WATTS - WHITE</u>				4. DATE OF DEATH <u>FEBRUARY - 25 - 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER - 18 - 1884</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>'RETIRED'</u>			
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. CO. MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN E. WHITE</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA LEONARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-09-6708</u>			
17. INFORMANT <u>MRS. AGNES P. WHITE</u>				Address <u>HAGERSTOWN MD. R. 3</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral haemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Heart</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>3 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 22</u> 19 <u>60</u> to <u>Feb 25</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Feb 24</u> 19 <u>60</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. Le Van</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/26/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Le Van</u>				22d. ADDRESS <u>Boonsboro, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 27 - 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Reed</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF TEXAS
COUNTY OF DALLAS

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1

CHIEF

CLERK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2590

CERTIFICATE OF DEATH

Reg. Dist. No.

02613

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle Ernde Last Whittington				4. DATE OF DEATH Month Feb. Day 12 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1 1878		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 10 Days 10	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George Crowe				14. MOTHER'S MAIDEN NAME Mary Eugenia Wolfe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Mrs. Dorothy Hale Address 830 Virginia Ave. Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive vascular Disease DUE TO 10 yr (c) generalized arteriosclerosis DUE TO 15 yr							INTERVAL BETWEEN ONSET AND DEATH 4 & 6 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① hypochromic microcytic anemia - severe							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 10, 1956 , to Feb 12, 1960 , that I lost saw the deceased alive on Feb 12, 1960 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edward W. Ditto M.D. 217 West Washington Street 2/13/60							
ACTUAL SIGNATURE Edward W. Ditto M.D. 217 West Washington Street 2/13/60							
PHYSICIAN'S NAME (Type) Edward W. Ditto 111, M. D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 15-60		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Lef ADDRESS Williamsport Md.				24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING 18
2500
CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Date of Birth: _____

4. Place of Birth: _____

5. Date of Death: _____

6. Cause of Death: _____

7. Place of Death: _____

8. Signature of Physician: _____

9. Signature of Registrar: _____

10. Signature of Coroner: _____

11. Signature of Medical Examiner: _____

12. Signature of Nurse: _____

13. Signature of Undertaker: _____

14. Signature of Burial Society: _____

15. Signature of Cemetery: _____

16. Signature of Funeral Home: _____

17. Signature of Mortician: _____

18. Signature of Embalmer: _____

19. Signature of Crematorium: _____

20. Signature of Burial Society: _____

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2591

CERTIFICATE OF DEATH

02614

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 Yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>632 West Washington St</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>632 W. Washington</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ARTHUR</u> Last <u>WHORTON</u>		4. DATE OF DEATH Month <u>Feby</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Md. Hagerstown Wash Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Whorton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Coss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.# 1</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Emma P. Moats</u>		Address <u>653 No Mulberry</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. <u>420.1</u> (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic nephritis with hydronephrosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 19</u> , 19 <u>60</u> , to <u>Feb. 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 19</u> , 19 <u>60</u> , and that death occurred at <u>4 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		ADDRESS (Street, city or town, state) <u>148 West Washington St. M.D.</u> DATE SIGNED <u>2/18/60</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

STATE OF NEW YORK
CERTIFICATE OF DEATH

1904

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF MINISTER OF THE GOSPEL
SIGNATURE OF CLERK OF THE COURT

FILED
IN
VOLUME
PAGE
AT
NEW YORK
JAN 10 1904
CLERK OF THE COURT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, RFD</u>		c. LENGTH OF STAY IN 1b <u>1 Hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooklane Farm Hospital</u>				d. STREET ADDRESS <u>407 Washington St.</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN G. WIEBEL</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1883</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Allegheny, Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward L. Wiebel</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Zehner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Mrs. Georgia L. Wiebel, 407 Wash. St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General arteriosclerosis</u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. F. W. D. [Signature]</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>2/24/60</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Allegheny, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc., Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		PHYSICAL EXAMINATION _____	
LABORATORY EXAMINATIONS _____		OTHER EXAMINATIONS _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF REGISTRAR _____	
DATE _____		TIME _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2592

CERTIFICATE OF DEATH

Reg. Dist. No.

02616

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SHARPSBURG</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>KATHY</u> First Middle Last <u>LEE WILHIDE</u>			4. DATE OF DEATH <u>FEBRUARY 14 1960</u> Month Day Year				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEBRUARY 14 1960</u>		9. AGE (In years last birthday) yrs. <u>49</u> IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>DONALD RICHARD WILHIDE</u>			14. MOTHER'S MAIDEN NAME <u>MINNIE ELIZABETH DICKERHOFF</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (5 mos.)</u> <u>776 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>49 minutes</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 14</u> , 19 <u>60</u> , to <u>Feb 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 14</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney Novenstein</u>			ADDRESS (Street, city or town, state) <u>M.D. Sharpsburg Md.</u> DATE SIGNED <u>2-15-60</u>				
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Col Hospital Lab.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sidney Novenstein</u>				ADDRESS <u>Sharpsburg Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-23-60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Board</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

2593

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELMER Middle CALVIN Last WILLIAMS				4. DATE OF DEATH Month February Day 17 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 30, 1883	
9. AGE (In years lost birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station operator		10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) near Wolfsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Williams				14. MOTHER'S MAIDEN NAME Elizabeth Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 369-07-3241		INFORMANT Address Mrs. Elizabeth Hurd Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic heart disease & chronic decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO General arteriosclerosis (c) General arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 Pulmonary Emphysema and chr. cor pulmonale							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 9, 1959 to Feb 17, 1960 , that I last saw the deceased alive on Feb - 10, 1960 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto III, M.D.				ADDRESS (Street, city or town, state) 712 W. Washington St Hagerstown, Md		DATE SIGNED 2/18/60	
PHYSICIAN'S NAME (Type) Edward W. Ditto III, MD				Hagerstown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/1960		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home A. F. Samblin				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR FEB 23 '60	
				24b. REGISTRAR'S SIGNATURE G. L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2594

CERTIFICATE OF DEATH

02618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg -- rural RD 1	
3. NAME OF DECEASED (Type or print) Kathleen Regina Wolfe		4. DATE OF DEATH Month February Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1933
9. AGE (In years last birthday) 26 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Picked Beans	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hubert G. Wolfe		14. MOTHER'S MAIDEN NAME Della Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. lost	
17. INFORMANT Hubert G. Wolfe		Address Smithsburg, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Carditis 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 Mo. Birth.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. g. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-2 , 19 55 , to 2-9 , 19 60 , that I last saw the deceased alive on 2-9 , 19 60 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		ADDRESS (Street, city or town, state) DATE SIGNED 2-9-60	
PHYSICIAN'S NAME (Type) Charles F. Hess		Smithsburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel M.E. Cem.		22d. LOCATION (City, town, or county) (State) nr. Garfield Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 12 '60		24b. REGISTRAR'S SIGNATURE William E. Thomas	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02619

2595

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>36 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2327 Jefferson Blvd</u>		/ d. STREET ADDRESS <u>2327 Jefferson Blvd</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>EMMA</u> Last <u>YESSLER</u>		4. DATE OF DEATH Month <u>Feby</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Thurmont Fred Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Moser</u>		14. MOTHER'S MAIDEN NAME <u>Mary Russman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Ethel Rinehart</u>		Address <u>2327 Jefferson Blvd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arterio-sclerotic heart disease</u> (c) <u> </u>		Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/22</u> , 19 <u>60</u> , to <u>Feb 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>18 Feb</u> , 19 <u>60</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Cohen</u> M.D.		ADDRESS (Street, city or town, state) <u>115 W. 1st St. Hagerstown Md.</u>	
DATE SIGNED <u>2/20/60</u>			
PHYSICIAN'S NAME (Type) <u>E. Cohen</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Andrew K. Coffman</u>	

CERTIFICATE OF DEATH

2881

DEATH CERTIFICATE

1914

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2536

CERTIFICATE OF DEATH

Reg. Dist. No.

02620

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 1 Clearspring</u>			
c. LENGTH OF STAY IN 1b <u>24 hours</u>				d. STREET ADDRESS <u>none</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>Christine</u> Last <u>Yost</u>				4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>19 60</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1960</u>	
9. AGE (In years last birthday) yrs. <u>24</u>		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min. <u>24</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Frederick Yost</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ann Dabrow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>James F. Yost</u> Address <u>Clearspring, Md. Route 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion for tired</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary by Hyaline Membrane</u> DUE TO (c) <u>1 Day</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/14/60</u> , 19 <u>60</u> , to <u>2/15/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/15/60</u> at <u>23130 Ave</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Calvin Young</u> M.D.				ADDRESS (Street, city or town, state) <u>Big Spring Md.</u> DATE SIGNED <u>2/14/60</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Spring Furnace Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Big Spring Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>Clearspring, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 23 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081161X02

CERTIFICATE OF DEATH

COUNTY OF STATE BALTIMORE		DEPARTMENT OF HEALTH BALTIMORE	
NAME OF DECEASED MARY ANN JONES		SEX FEMALE	
DATE OF BIRTH JAN 15 1890		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION SEWING MACHINE REPAIRER		MARITAL STATUS SINGLE	
CAUSE OF DEATH TUBERCULOSIS OF LUNGS		PERIOD OF ILLNESS 6 MONTHS	
DATE OF DEATH DEC 10 1915		PLACE OF DEATH BALTIMORE, MARYLAND	
TIME OF DEATH 10:30 AM		NAME OF PHYSICIAN DR. J. H. SMITH	
NAME OF FUNERAL HOME JONES FUNERAL HOME		NAME OF MINISTER REV. W. B. WHITE	
NAME OF BURIAL PLACE GREENWICH CEMETERY		NAME OF INTERMENT INTERMENT	
NAME OF NEXT OF KIN MRS. J. H. JONES		NAME OF WITNESS J. H. JONES	
NAME OF REGISTRAR J. H. JONES		NAME OF CLERK J. H. JONES	

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.
 IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE DEATH IS PROPERLY REGISTERED.
 THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE OR FOR THE RESULTS OF ANY ACTION TAKEN THEREON.
 THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE OR FOR THE RESULTS OF ANY ACTION TAKEN THEREON.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG257 2-24-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 302

2604

02621

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>2 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>Frederick</u> <u>1011-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home</u>				d. STREET ADDRESS <u>613 Charles Street</u> <u>Homewood Church Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>Z</u> Last <u>ZEIGLER</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 23 1866</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Con Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Henry Zeigler</u>				14. MOTHER'S MAIDEN NAME <u>Rosanna Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Homewood Church Home Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <u>Rev Mark Wagner Williamsport Md</u>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>422.1</u> DUE TO <u>minute</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerosis General</u> DUE TO <u>years</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1959</u> , 19 <u> </u> , to <u>2-11-60</u> , that I last saw the deceased alive on <u>2-10-60</u> , 19 <u> </u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis G. Graff</u>				ADDRESS (Street, city or town, state) <u>119 E. Antietam St.</u>		DATE SIGNED <u>2-12-60</u>	
PHYSICIAN'S NAME (Type) <u>Louis G. Graff, M.D.</u>				<u>Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Fred. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hume</u>	
				DATE <u>FEB 17 '60</u>			

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2597

CERTIFICATE OF DEATH

Reg. Dist. No.

02622

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural 10x-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Christian zinkhan				4. DATE OF DEATH Month Day Year Feb. 29 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1881		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Zinkhan				14. MOTHER'S MAIDEN NAME Mary Shriner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-9482		17. INFORMANT Mrs. Anna Zinkhan		Address Thurmont, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) General Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH minute 2 yrs + 10 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Intestinal Obstruction due to Internal Hernia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 20, 1960 , to Feb. 29, 1960 , that I last saw the deceased alive on Feb. 28, 1960 , and that death occurred at 6:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard V. Hauver M.D.				ADDRESS (Street, city or town, state) Hagerstown, Md		DATE SIGNED 2/29/60	
PHYSICIAN'S NAME (Type) Richard V. Hauver				(247 N. Potomac St)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-60		22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR MAR 3 '60	
				24b. REGISTRAR'S SIGNATURE William S. Kline			

CERTIFICATE OF DEATH

NAME OF DECEASED Raymond A. Gossard		SEX Male		AGE 32-34		DATE OF DEATH April 1, 1920	
PLACE OF DEATH Boston, Mass.		TIME OF DEATH 10:30 A.M.		DAY OF DEATH Monday		MONTH OF DEATH April	
PLACE OF BIRTH New York, N.Y.		TIME OF BIRTH 10:30 A.M.		DAY OF BIRTH Monday		MONTH OF BIRTH April	
OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF INTERMENT Mount Hope Cemetery	
NAME OF PHYSICIAN Dr. J. H. Gossard		NAME OF FUNERAL HOME Blue Ridge Cemetery		NAME OF UNDERTAKER Thymon, Maryland		NAME OF BURIAL PLACE Thymon, No. 1	
NAME OF NEXT OF KIN Mrs. Anna Zinkhan		NAME OF WITNESS Henry Zinkhan		NAME OF WITNESS Mary Zinkhan		NAME OF WITNESS U.S.A.	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 10